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CARING FOR VETERANS IN RURAL AREAS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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FEBRUARY 26, 2009

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CARING FOR VETERANS IN RURAL AREAS

THURSDAY, FEBRUARY 26, 2009

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:06 a.m., in room SR–418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Tester, Begich, Burris, Burr, and Johanns.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. This hearing on Caring for Veterans in Rural Areas will come to order.

Good morning and aloha to all of you. I want to extend my warmest welcome to our Committee Members—it is good to see Senator Tester here early—and also to welcome our witnesses visiting the Nation's capital from small communities as close as southern Virginia and as far away as Montana. Today's hearing brings together small communities with VA to discuss the health care problems our newest veterans face when they return to homes in rural areas.

Many of our veterans live in small towns and communities. This includes a large number of Guard members and Reservists, who have been such a big part of the wars in Iraq and Afghanistan. Members of the Guard and Reserve face challenges different from their active-duty counterparts, who return to military bases with the support of their unit with programs geared toward reacclimating them to life outside of the combat zone.

When a Guardsman or Reservist returns home, he or she can be isolated from their unit and must reintegrate without a strong VA or DOD presence or support system. Frequently, these servicemembers live up to and beyond, 50 miles from their home base.

When health care is needed, a rural community may not have providers who offer mental health services like group counseling or therapy. The doctors may not be familiar with treating combat-related disorders.

Nevertheless, we have an obligation to care for all our veterans in need, regardless of location. We must ensure that adequate resources are available in our small communities, and that VA engages fully with local health care providers. Every resource must be united in the effort to care for our wounded warriors, be it a community hospital or VA clinic. When there is no VA presence

available, this may mean paying community providers for the reasonable costs of care.

As a Committee, we will be focusing much effort on improving veterans' health care in rural areas, and I welcome any new approaches to meet this goal.

I also want to tell you that I just had a conversation with Secretary Shinseki before coming into the room. We discussed the proposed VA budget. I must say that with the little detail we do have, it is positive. I can tell you that there will be an increase in the veterans' budget that will be proposed by the President to the VA and to Secretary Shinseki. And let me say that it is a step in the right direction. It is an increase. We are looking at about 15 percent, but it is a step in the direction of the needed resources.

The President's budget and its discretionary authority increases health care funding by $5 billion over last year's budget, so that is a good step. And I am looking forward to seeing more of the President's proposal in the days and weeks to come. And we do, of course, have VA's budget hearing scheduled for March 10th.

So let me call on Senator Tester for his opening statement.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Chairman Akaka. I appreciate your holding this hearing today, and I want to thank the distinguished witnesses who are here today to discuss health care and the challenges faced by veterans living in rural communities.

I also want to recognize Matthew Kuntz. Matthew is an attorney from Helena, Montana. He gave up his practice as an attorney to serve as Executive Director of the National Alliance on Mental Illness, NAMI, in Montana, and this happened after his step-brother committed suicide. I have been very, very fortunate over the last couple of years to get to know Matt, and I believe he adds a very important voice to this story.

Matt's brother was an Iraqi war veteran suffering from combat-related PTSD, and I want to thank him personally for his leadership and his advocacy on this issue. His outreach has been a lifeline for Montana veterans and their families. We appreciate your courage, Matt, and the perspective that you will bring to this Committee today.

This is not an easy topic, but we must continue to address combat-related mental illness and the devastating effects that it can have on veterans, because if it is not properly identified and expeditiously treated, the problems do not get better. They get worse.

Again, I want to thank you for coming and thank you for bringing awareness from a Montana perspective.

Montana has a large population of Native American veterans. This is a special group of veterans that is disproportionately affected by service-connected health conditions. Their access to primary and mental health care is further limited by distance, it is underfunded and often provided by inadequate community health care services through the IHS. We need to do better there.

Next month, I intend to reintroduce the Rural Veterans Health Improvement Act. I will work with my colleagues and the Chairman on this Committee to be sure that this bill includes a section

on improving the VA's work with IHS, because I think we all know that the relationship as it stands is not working properly. We did not have anything on the VA-IHS relationship last time, but I believe we need to address it.

Veterans who reside in frontier communities like Montana are at greater risk of adverse health outcomes. They cannot wait weeks for a VA appointment in a city hundreds of miles away with a doctor that they have never seen or who has no knowledge of their medical history. In many instances, the primary care setting, whether it is in the CBOCs or some kind of private provider in the local community, becomes the de facto mental health care delivery system for these individuals.

More than 40 percent of the patients with mental health concerns initially seek care in the primary care setting, and I believe we have to take a look at this because the primary care setting provides a valuable opportunity to improve access to mental health services.

I believe there is a greater opportunity for the VA to collaborate and support primary care settings in local communities. If the VA cannot provide timely, targeted access for veterans in rural areas, whether for mental health or for physical injuries suffered in service to our Nation, then they must expand and build upon resources in the local community with an eye toward improving access, communications, and follow-up.

Again, I appreciate, Mr. Chairman, your calling this hearing, and I appreciate the opportunity to hear from the witnesses as we progress today. Thank you.

Chairman AKAKA. Thank you very much, Senator Tester. I want to mention that you are regarded as a leader here on rural health, so we are so glad to have you as a Member of this Committee.

Let me call on Senator Burr for his opening statement.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Aloha, Mr. Chairman.

Chairman AKAKA. Aloha.

Senator BURR. I think it is evident to all of us that Senator Tester got his hair cut while he was gone. He desperately needed it at the last hearing. I just want to point that out. [Laughter.]

Mr. Chairman, I want to thank you for this hearing and good morning to our witnesses.

About one-third of all veterans enrolled for VA health care live in rural communities as defined by the Census Bureau. Many of us can point to large portions of our States that have limited access to health care, and North Carolina is no exception to that. I am convinced we must tackle this problem, and I am eager to hear what the witnesses from VA are doing to solve it.

I am pleased that in recent years the VA has continued to expand its presence of outpatient clinics in rural communities. VA has opened over 100 new community-based outpatient clinics in the past 5 years. I have had the pleasure of attending several VA clinic openings in North Carolina over the last couple of years. We have four more that will open within the next 2 years. These clinics will cut down on lengthy travel times and hopefully encourage veterans

to get the essential primary care and basic mental health services that they might not otherwise seek.

Let me add at this point, Mr. Chairman, it is my intention to bring to this Committee, hopefully, a new model program for rural markets where we consider collocating VA outpatient clinics in with federally chartered community health centers, where we share the footprint of a delivery point and, potentially at least, share the technology components of X-ray, copiers, the things that we do not need to duplicate; and we will work out the professional staff if there is any sharing along those lines. But I think it is time that we begin to think outside of the box for how we increase the number of points that deliver health care—facing the reality that if we are unsuccessful at doing that, we will never accomplish the level of primary care that is needed to make sure that our veterans are not, in fact, inpatient fatalities within the system.

Along with these new clinics is the opportunity to expand our use of telemedicine. That technology now permits remote consultations and even some medical procedures or examinations to occur in the comfort of a patient's own home, which I would say we have done with great success thus far.

As this technology continues to improve, it will open the doors to deliver more care to more veterans in remote areas.

Finally, access to care for rural veterans raises the potential to work in coordination with health care providers in rural areas, as I have said, and this is a tremendous area of interest to veterans who live in these rural areas and are faced with the decision of how to get from where they live to a delivery point when travel seems to be their number 1 concern.

Last year Congress passed legislation to test this concept with a pilot program allowing the VA to team up with community providers for the care of veterans who live far away from VA facilities, and I look forward to hearing how those pilot programs are going.

Mr. Chairman, again, I thank you again for calling this important hearing. I do not believe that there is any area of greater concern than how we address the delivery of health care in rural America, particularly as we continue to see the demographic shift that is happening in this country. I go into this with the realization that many of those retired veterans are choosing North Carolina to be their home and that we cannot possibly, without the right amount of attention in rural markets, understand how we are going to service this population, regardless of which State they choose, unless we are willing to tackle new ways to deliver health care in the rural areas of this country.

I thank the Chair.

Chairman AKAKA. Thank you very much, Senator Burr.

Let me call now on Senator Burris for his opening statement.

STATEMENT OF HON. ROLAND W. BURRIS,
U.S. SENATOR FROM ILLINOIS

Senator BURRIS. Thank you, Mr. Chairman, and I want to thank the witnesses for appearing here as well.

Mr. Chairman, over the break I was not able to go to a rural VA hospital, but I visited the most modern one up in Great Lakes in northern Illinois, and I was impressed with the move to combine

the medical services from the naval base over at Great Lakes with the veterans hospital. They are doing this as the only program in the country that is trying to do complete service with DOD and with the VA. The hospital administrators are all excited about it. The Navy leadership is all excited about it. But it is not getting to our rural communities, and we have rural communities in Illinois as well.

As you all may know, there was that one incident in Illinois where that one doctor created a lot of problems for some veterans, and I understand that that has really been taken care of. But we have to be concerned about how they get access to health care. And when you see that 39 percent of the veterans enrolled in the VA health care system reside in rural areas, the model we have for providing care to veterans via large hospitals and clinics does not make sense in areas of low population density. We must find new ways to serve our rural veterans. And I hope a newly created Office of Rural Health and those clinics will find ways to eliminate the discrepancies in the care between urban, suburban, and rural veterans.

There are some urgent issues right now that we must face, and we must solve them on behalf of the members who gave their all for us to be safe in this great democracy. We cannot forget them. We cannot let them suffer. We must take care of them.

Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burris.

Senator Begich, your opening statement, please.

STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you, Mr. Chairman. I am going to be, as usual, brief, and say thank you. I am looking forward to your commentary. There is no State more rural than Alaska, and how you deliver health care systems up there causes grave concerns.

I appreciate Senator Burr's comment regarding delivery to rural communities.

I like pilot ideas, but I like aggressive approaches. I think the system has to change dramatically, especially in Alaska, in how we partner with, for example, some of the best health care that is offered in regards to our Native health care systems that are all throughout the State of Alaska. And I know there are a couple ideas that are being kicked around. They are kind of jammed up a little bit, from what I understand. I am looking forward to seeing a long-term, aggressive approach in especially what I would consider the most rural of rural States in this country and how you deliver health care systems.

So, I am looking forward to your testimony. I know we are going to be voting at 10:30. I do not know how this will all work, but I am looking forward to it. If I miss it, I am anxious to hear from both of you at a later time.

Chairman AKAKA. Thank you, Senator Begich.

Senator Brown?

STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman, and thank you to the witnesses for being here and for your public service. Thank you.

In my State of Ohio, of 11 million people, there are more than 1 million veterans, and that number is growing rapidly, of course, as men and women return from Iraq, Afghanistan, and other deployments. These brave men and women were made a solemn promise that if they defended our country, we would provide them with services they have earned and they deserve.

Veterans in rural America and rural Ohio face barriers, as others have pointed out, to healthy transition to civilian life. From a lack of access to VA facilities to a lack of VA reimbursement for community hospitals, rural veterans are struggling to regain a healthy life. That is why this hearing is so important, and I thank the Chairman for doing this.

Last year I held a joint field hearing with Congressman Zack Space—now a two-term Member from Ohio—which examined issues facing veterans in Appalachia, Ohio. During the hearing I heard from Terry Carson, the CEO of Harrison Community Hospital, a 25-bed community hospital that serves the small village of Cadiz—the boyhood home of both Clark Gable and General George Custer, I might add. I asked Mr. Carson to testify after receiving a letter from him describing the enormous financial strain that small community hospitals experience when they provide urgent care for veterans, despite knowing the hospital may not receive VA reimbursement.

After hearing Mr. Carson's story and that of other community hospitals treating rural veterans, I introduced and this Congress enacted the Veterans Emergency Care Fairness Act of 2007 that requires the VA to reimburse community hospitals for all care a veteran receives before that veteran is transferred to another VA facility.

But that act addresses just one issue that confronts veterans in rural areas. Today's hearing examines important issues of recruitment of physicians in rural communities, strengthening telemedicine resources to compensate for the shortage of providers in rural communities, and other ways to ensure a concerted effort to provide adequate health care for our veterans.

Much work needs to be done. Veterans, whether living in Cadiz or Cleveland, deserve access to the quality health care that honors their sacrifice.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Brown.

Senator Murray?

STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. We do have a vote in just a couple minutes, so I will put my opening remarks into the hearing record. And I would just say that I think this is a critical, critical hearing, and I look forward to your testimony and the opportunity to talk to all of our witnesses today about how we are going to address these needs.

Mental health is something that I have talked about for a long time. Concerning mental health needs, it is very hard in rural communities when we expect people to drive miles and miles, hours at a time, to get the help they need. It just does not happen.

So, we have a lot of work ahead of us, and I am concerned about—as all of our colleagues have talked about—what we can do to make sure that we are taking care of our veterans wherever they live. I look forward to this hearing.

Thank you very much.

[The prepared statement of Senator Murray follows:]

PREPARED STATEMENT OF PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Mr. Chairman, Senator Burr, thank you very much for holding today's hearing to assess how well the VA is caring for veterans in rural areas.

Before I begin, I want to thank today's witnesses for coming here to testify. And I look forward to hearing from them shortly.

Mr. Chairman, as you know, about 40 percent of all veterans who use the VA health care system today live in rural areas. And that's true of nearly half of the servicemembers in Iraq and Afghanistan now.

But making sure those veterans can access care is one of the many problems we're still struggling to address.

The VA has done a tremendous amount of work to increase access in rural areas by establishing:

- new Community Based Outpatient Clinics—or CBOCs,
- Vet Centers, and
- Mobile Medical Units.

But we still have gaps in our ability to reach veterans who need care. And I can tell you that it's one of the most common complaints I hear from veterans from my home state of Washington.

Many tell me they have to drive several hours—through snowy and icy conditions in the winter time—just to see their doctor and get basic care.

As you know, many of our veterans are getting up there in age, and this is a real strain on their health—and on their finances. Unfortunately, the result is that many of them end up putting off preventive—and sometimes even necessary—treatment. And that's taking a real toll on their health.

The VA's studies have found that rural veterans are in poorer health than those living in urban areas where care is more accessible.

Congress and the VA have recognized the problem, and we've taken some proactive steps to correct this injustice:

- We created an Office of Rural Health within the VA to improve the delivery of care to rural veterans.
- We increased the mileage reimbursement to 41.5 cents per mile so that travel is more affordable.
- We increased outreach efforts to make sure more veterans are informed about their health care and benefits.
- We're taking advantage of new technology, like telemedicine, to compensate for the shortage of providers in rural areas.
- And we've created more CBOCs. The CBOCs in my home state have made a big difference for veterans on the Olympic Peninsula and in the city of Wenatchee. And we're looking forward to the permanent opening of the Northwest Washington CBOC as well.

But while each of these steps has been a significant improvement over the past, we still have work to do. Among other things, I want to make sure the VA's Office of Rural Health has the resources to meet its full potential. And I also want to ensure our rural veterans can get access to the best mental health care possible.

As many of us from rural states know, it can be very difficult to access to mental health care when you live miles from the nearest big city.

And so from recruiting and retaining health care providers in rural VA facilities—to monitoring and managing the quality of care provided in non-VA facilities—the challenges are complex.

And, while I realize there simply is not a silver bullet solution, we need to keep thinking about creative solutions to this serious problem.

So today, I look forward to hearing from our witnesses about their experiences and the steps they're taking to improve the care of our veterans living in rural

areas. I hope this discussion will help us develop new ideas to make sure all of our veterans can get the care they have earned.

And again, I thank you, Mr. Chairman, for holding this hearing.

Chairman AKAKA. Thank you very much, Senator Murray.

As you know, we are expecting a roll call on the floor, but in the meantime, let me welcome our first panel of witnesses. We will hear first from Kara Hawthorne, Director of the Office of Rural Health for Virginia. The Office of Rural Health was created by Public Law 109–461 to address the needs of our rural veterans. We will hear today how her office has been addressing these needs.

Second, we will hear from Dr. Adam Darkins, who runs VA's telehealth program.

I want to thank you all for joining us today. Your full statements will appear in the record, and, Ms. Hawthorne, before we have the vote on the floor, please proceed with your statement.

STATEMENT OF KARA HAWTHORNE, DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. HAWTHORNE. Good morning, Mr. Chairman and Members of the Committee. I am delighted to be here today to talk to you about the very important work that VA is doing to enhance the care delivery to veterans who live in rural and highly rural areas. I would like to request that my written statement be submitted for the record.

Let me begin by saying that we know rural health is a difficult national health care issue. Veterans and other citizens face a number of challenges. But VA has aggressively pursued a national strategy of outreach to ensure that veterans, regardless of where they live, can access the expertise and experience of one of the best health care systems in the Nation. In partnership, I know that Congress and VA can do even more. We do deeply appreciate your support and interest in this area, and we are happy to report that portions of the $250 million included in this year's appropriation have already been distributed to the field to support new and existing projects.

In January, VA provided almost $22 million to VISNs across the country to improve services for rural veterans. VA's Office of Rural Health, or ORH for short, has allocated another $24 million to sustain fiscal year 2008 programs and projects, including the Rural Health Resource Centers, Mobile Health Care Clinics, Rural Outreach Clinics, VISN Rural Consultants, mental health and long-term care projects, and rural home-based primary care.

Another project supported by Congress is Section 403 of Public Law 110–387. This section requires VA to conduct a pilot project that would provide non-VA care for highly rural enrolled veterans in five VISNs. VA is working to implement this pilot while resolving two questions.

First, we must reconcile how VA has traditionally defined "highly rural" and how the statute defines it. VA's data has been structured based upon our definitions using drive times, and we are currently analyzing that data to develop a new baseline assessment using mileage.

Second, VA must develop a regulation to define the "hardship provision" in Section 403(b)(2)(B). We have been active in our development of an implementation plan, and once that assessment and the regulatory process are complete, VA will identify qualifying communities and local providers willing and able to participate. VA staff is available to meet with Members of the Committee or staff to discuss additional ways forward.

ORH's primary mission is to address the needs of rural veterans and improve access and quality of care, and its mission is in our mind at all times. VA understands that veterans can only use our services if they know about them, so VA has initiated a Veterans Call Center that has been reaching out to OEF/OIF veterans from all parts of the country to inform them of their benefits and ask if they need any help. ORH will be reviewing the Call Center's work to determine what more we can do for rural veterans.

We are also in close collaboration with HHS to address the needs of the OEF/OIF veterans by coordinating seamless referrals from community health centers to VA medical centers and sharing VA's wealth of educational material.

One of the most significant health care challenges in rural and highly rural areas is the shortage of health care providers, particularly specialty care providers. VA is working diligently to develop and implement creative solutions that will provide incentives and opportunities to bring qualified health care providers to these areas.

For example, we are currently 1 year into a 3-year pilot for VA's Travel Nurse Corps, which is designed to improve recruitment, decrease turnover, and maintain high standards of patient care. Additionally, VHA Office of Health Care Retention and Recruitment is establishing a national contract for retained search firms and is hiring recruiters who will focus on rural areas. VA also continues to grow education debt reduction and recruitment, retention, and relocation programs.

The Office of Rural Health embraces technology as an essential component for expanding care and increasing access for rural veterans, and we are identifying new ways to collaborate with the community. In coordination with VA's Office of Information and Technology and VHA's Office of Health Information, we are exploring opportunities to exchange information with non-VA providers through the use of the Nationwide Health Information Network.

Another innovative approach that has been piloted uses text messaging to help veterans send their home-based blood pressure readings to their clinicians. Researchers found that veterans who use this method achieve their blood pressure goals 2 weeks sooner than those using other methods.

My Health*e*Vet is another example of technology at work. It offers veterans access to the personal health record anytime, anywhere. Veterans access My Health*e*Vet through an Internet-based, secure, and convenient portal that allows veterans to renew and refill prescriptions online, review medical information, self-report their clinical data, schedule and view appointments, and view wellness reminders. ORH will ensure that My Health*e*Vet meets the needs of rural veterans and directly supports their care.

My colleague Dr. Darkins will discuss the important role that telehealth plays in harnessing technology for improved access for rural veterans as well.

Mr. Chairman and Committee Members, the VA's Office of Rural Health is working with every available partner to coordinate and support programs aimed at increasing access for veterans in rural and highly rural communities. Let me conclude by assuring you that we share your passion for this effort, and we are prepared to address any questions that you may have.

[The prepared statement of Ms. Hawthorne follows:]

PREPARED STATEMENT OF KARA HAWTHORNE, DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Good morning, Mr. Chairman. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA's) work to enhance the delivery of health care to Veterans in rural and highly rural areas. This is an issue of significant importance to the Department and we look forward to working together with the Committee in the coming session to ensure Veterans in geographically remote areas receive the care they have earned through service to our country.

On behalf of the Secretary and the Under Secretary for Health, I'd like to welcome the newest Members of the Committee: Senator Mark Begich, from Alaska; Senator Roland Burris, from Illinois; and Senator Mike Johanns, from Nebraska. Each of you represents a state that is home to rural Veterans and I know this hearing will cover a topic of great import to you. We are very interested in hearing your ideas and concerns on this issue today and on others on future occasions.

As the Secretary has said, rural health is a difficult national health care issue. Veterans and others who reside in rural areas face a number of challenges associated with health care. The published literature suggests that greater travel distances and financial barriers to access can negatively impact care coordination for many rural Veterans. VA has pursued a national strategy of outreach to ensure Veterans, regardless of where they live, can access the expertise and experience of one of the best health care systems in the country. In partnership, Congress and VA can do even more. We deeply appreciate Congress' support and interest in this area, and we are happy to report portions of the $250 million included in this year's appropriation have already been distributed to the field to support new and existing projects.

VA's rural health strategy reflects the insight and counsel of experts both inside government and out. Our approach is four-fold:

- First, we have created an Office of Rural Health that coordinates efforts in programs across the Veterans Health Administration to reduce redundancy and disseminate best practices;
- Second, we are leveraging existing resources in communities across the land to raise VA's presence through Outreach Clinics, fee-basis and contracting, and mobile vans;
- Third, we are actively addressing the shortage of health care providers through recruitment and retention efforts; and
- Finally, we are harnessing technology to remove barriers to care and bring the best experts in the world to every corner of the country, and to empower Veterans as active participants in their health care through telehealth, which my colleague, Dr. Darkins, will address in his statement.

Before I begin discussing these issues in greater detail, I would like to share with you how VA defines urban, rural, and highly rural as categories. Our definitions are based on the U.S. Census Bureau's definition, which designates areas down to the census block level. The Census Bureau defines urban as all territory, population, and housing units within an urbanized area or an urban cluster. An urbanized cluster consists of a core census block group or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. Urban clusters are found in small towns surrounded by a lower density population. Urbanized areas consist of contiguous densely settled block groups that along with adjacent densely settled census blocks together encompass a population of at least 50,000 people. VA defines urban enrollees as any enrollees who are located within a Census-defined urbanized area. Rural enrollees are any enrollees not designated as urban (including those who live within urban clusters), while highly rural enrollees reside in counties with

fewer than seven civilians per square mile. Based on VA's definitions, approximately 60 percent of enrolled Veterans reside in urban areas, while approximately 37 percent reside in rural areas. Fewer than two percent reside in highly rural areas.

OFFICE OF RURAL HEALTH

VA's Office of Rural Health (ORH) was authorized by § 212 of Public Law 109–461 and empowered to coordinate policy efforts across VHA to promote improved health care for rural Veterans. One of the mandated functions of ORH includes the designation in each Veterans Integrated Service Network (VISN) of Rural Consultants who are responsible for consulting on and coordinating the discharge of ORH programs and activities in their respective VISN for veterans who reside in rural areas. These consultants are enhancing service delivery to Veterans residing in rural areas and will lead activities in building an ORH Community of Practice, which will facilitate information exchanges and learning within and across VISNs, while providing a crucial link between ORH and VISNs. The authorizing legislation required each VISN identify a Consultant; VA is currently conducting a pilot program in eight VISNs with full-time consultants to determine if this staffing level is more appropriate than a part-time position. The VISN Rural Consultant Pilot Project facilitates information exchanges and learning across VISNs and to VA Central Office. The Pilot collaborates with local communities through outreach, education and other activities to ensure Veterans' access to quality care reflect local needs and conditions; each rural area is different and there is no "one size fits all" strategy we can adopt. Consequently, our Pilot is focused on engaging the VISNs in rural planning efforts to properly allocate resources and to support complementary efforts.

In addition, VA has created a 13-member VA Rural Health Advisory Committee to advise the Secretary on issues affecting rural Veterans. This panel includes strong advocates for the needs of Veterans in rural areas. It includes physicians from rural areas, Veterans, and experts from government, academia and the nonprofit sectors. Earlier this month, Secretary Shinseki appointed Dr. Susan Karol, from the Indian Health Service, as an ex officio member on the Advisory Committee. We welcome Dr. Karol's appointment and the expertise she will bring. The Advisory Committee will meet in Phoenix on March 3 and 4. A primary focus is to support collaborations with non-VA organizations, and in this regard, VA is making remarkable progress. VA has conducted outreach and developed relationships with the Department of Health and Human Services (including the Office of Rural Health Policy and the Indian Health Service), other agencies and academic institutions committed to serving rural areas. VA has also reached out through ORH to other government and non-governmental organizations, including the National Rural Health Association, the National Organization of State Offices of Rural Health, the National Institute of Mental Health Office of Rural Mental Health, the National Cooperative Health Networks, the Rural Health Information Technology Coalition, the Rural Assistance Center, the Rural Health Resource Center, the Georgia Health Policy Center, various rural health research centers, and other organizations to further assess and develop potential strategic partnerships. ORH is working in close collaboration with the Department of Health and Human Services to address the needs of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans to coordinate services with the Department of Health and Human Services' Health Resources and Services Administration Community Health Centers. These initiatives include a training partnership, technical assistance to Community Health Centers and a seamless referral process from Community Health Centers to VA medical centers.

VA opened three Rural Health Resource Centers at the start of this Fiscal Year. These centers develop special practices and products for use by facilities and networks across the country. The eastern Center is located at the White River Junction VA Medical Center in Vermont; the Central Center is at the Iowa City VA Medical Center in Iowa; and the Western Center is at the Salt Lake City VA Medical Center in Utah. Each Resource Center is appropriately staffed with administrative and clinical personnel who are identifying disparities in health care for rural Veterans. They are also developing processes and measures of health care outcomes to evaluate and pursue the most effective programs and direct resources accordingly. These Centers essentially serve as field-based clinical laboratories capable of experimenting with new outreach and care models. They also serve a crucial function in enhancing academic affiliations with nursing and medical schools and help promote direct outreach to Veterans.

In January, VA provided almost $22 million to VISNs across the country to improve services for rural Veterans. This funding is part of a two-year program and will focus on projects including new technology, recruitment and retention, and close

cooperation with other organizations at the Federal, state and local levels. Funds will be used to sustain current programs, establish pilot programs and establish new outpatient clinics. VA distributed resources according to the proportion of Veterans living in rural areas within each VISN; VISNs with less than three percent of their patients in rural areas received $250,000, those with between three and six percent received $1 million, and those with six percent or more received $1.5 million. ORH has allocated another $24 million to sustain Fiscal Year 2008 programs and projects, including the Rural Health Resource Centers, Mobile Clinics, Outreach Clinics, VISN Rural Consultants, mental health and long-term care projects, and rural home based primary care. ORH convened a workgroup of VISN and Program Office representatives to plan for the allocation of the remaining funds. Earlier this month, ORH distributed program guidance to VISNs and Program Offices concerning allocation of the remaining funds as early as May to enhance rural health care programs.

VA's ORH, in its short time in existence, has produced a number of programs that are actively improving the delivery and coordination of health care services to rural Veterans. Some examples include:

- Expanding VA's existing Home Based Primary Care and Medical Foster Home programs (part of VA's Community Residential Care Program) into rural VA facilities with startup funding for Fiscal Year 2008 and partial funding for Fiscal Year 2009;
- Developing the "Geri" scholars program, in collaboration with VHA's Office of Geriatrics and Extended Care, to target VA geriatric providers in rural areas and provide them with an intensive course in geriatric medicine and a tailored training program on providing geriatric medicine in rural VA clinics with curricula and supportive activities based on a needs assessment of each participant;
- Developing the "Idea Award" to reach beyond the Veterans Rural Health Resource Centers so additional staff and program offices can participate in pilot projects, studies and analyses, as appropriate; and
- Building relationships with complementary Federal or non-Federal programs and organizations, as described above.

One area of particular importance to ORH is American Indian/Alaska Native, Native Hawaiian and Pacific Island Insular Area Veterans. The VISN Tribal Veterans Representative Program is an inter-agency initiative between the Indian Health Services, Tribal Health Services, Community Health Centers, and Veterans Service Organizations. The Program was developed to provide outreach and open communication to Veterans in extremely rural and underserved areas, especially the American Indian/Alaska Native, Hawaiian Native, and Pacific Island Insular Area populations. The Program trains individuals on outreach techniques to assist, facilitate and encourage Veterans to access the full range of VA benefits they earned through service. There are approximately 185 Tribal Veterans Representatives throughout the Nation working with Veterans and their families.

While Dr. Darkins will address telehealth and its unique benefits for rural Veterans, other technologies are also paving the way for easier access and better quality care. Rural communities have limited capital for health information technology investment, and the likelihood for rapid changes in technology and the absence of national technical standards pose additional challenges. Health information exchanges or regional health information organizations have been created in many localities to test the electronic exchange of protected health information, and VA is establishing connections with these successful networks.

Possibly VA's most promising expansion is My Health*e*Vet, which offers Veterans access to their personal health record any time, anywhere. This program was first launched in 2003. Veterans access My Health*e*Vet through an internet-based, secure and convenient portal that allows Veterans to improve their individual health through direct access. Access to this information helps the Veteran and the Veteran's providers, whether in VA or elsewhere.

Veterans can renew and refill prescriptions online, review medical information, self-report clinical data, schedule and view appointments and view wellness reminders. My Health*e*Vet reduces duplicate testing and increases our ability to prevent conditions from becoming worse by managing chronic diseases and adhering to evidence-based practices for quality care. ORH is working to ensure My Health*e*Vet meets the needs of rural Veterans and aids in their coordinated care.

COMMUNITY RESOURCES

VA recognizes that local problems require local solutions, and by identifying the resources already available, we can work together with each community to tailor solutions to their needs. We also understand Veterans can only use our services when

they know about them. To that end, VA began a Veteran Call Center Initiative in May 2008 to reach out to OEF/OIF Veterans from all parts of the country who separated between FY 2002 and July 2008. The Call Center representatives inform Veterans of their benefits, including enhanced health care enrollment opportunities and to see if VA can assist in any way. This effort initially focused on approximately 15,500 Veterans VA believed had injuries or illnesses that might need care management. The Call Center also contacted any combat Veteran who had never used a VA medical facility before. Almost 38 percent of those we spoke with requested information or assistance as a result of our outreach. The Call Center Initiative continues today, focusing on those Veterans who have separated since September 2008. ORH will be reviewing the work of this and other Call Centers to determine what VA can do to reach out more effectively to rural Veterans.

Community based outpatient clinics (CBOCs) have been the anchor for VA's efforts to expand access to Veterans over the last ten years. CBOCs have proven to be instrumental in greatly improving access to high quality care in a cost-effective manner. Our most recent strategic planning guidance focused specifically on underserved areas, which are defined as those where less than 70 percent of enrollees are within the access drive time guidelines for primary care; these guidelines are within 30 minutes for urban and rural Veterans and within 60 minutes for highly rural areas.

Beyond our CBOCs, VA utilizes rural outreach clinics that offer services on a part-time basis, usually a few days a week, in rural and highly rural areas where there is insufficient demand or it is otherwise unfeasible to establish a full-time CBOC. The clinics offer primary care, mental health services and specialty referrals. Each rural outreach clinic is part of a VA network and maintains VA's quality standards. Veterans can use rural outreach clinics as an access point for referrals to larger VA facilities for specialized needs. Last September, VA announced the opening of 10 new Rural Outreach Clinics this Fiscal Year.

Vet Centers also provide services and points of access to Veterans in rural communities. Vet Centers welcome home Veterans with honor by providing quality readjustment counseling in a supportive, non-clinical environment. By the end of FY 2009, VA will have 271 Vet Centers and 1,526 employees to address the needs of Veterans; any county in the country with more than 50,000 Veterans will have services available through a Vet Center. A fleet of 50 Mobile Vet Centers are being put into service this year and will provide access to returning Veterans and outreach to demobilization military bases, National Guard and Reserve locations nationally.

VA recently announced a Mobile Health Care Pilot Project in VISNs 1, 4, 19, and 20. These vans will be concentrated in 24 predominately rural counties, where patients would otherwise travel long distances for care. VA is focusing on counties in Colorado, Maine, Nebraska, Washington, West Virginia and Wyoming. This Pilot will collaborate with local communities in areas the vans visit to promote continuity of care for Veterans. It will also allow us to expand our telemedicine satellite technology resources and is part of a larger mobile asset work group. ORH is developing evaluation methodologies and measures to determine the effectiveness of this program and to identify areas for improvement.

Section 107 of Public Law 110–387 directs VA to conduct a pilot program in at least three VISNs to evaluate the feasibility and advisability of providing OEF/OIF Veterans with peer outreach and support services, readjustment counseling services, and other mental health services through arrangements with, among others, community mental health centers. VA's Office of Mental Health Services and the ORH are in the process of implementing this pilot program. The pilot will be conducted in a number of stages evaluating, in turn, the identification of rural areas that are beyond the reach of VA's mental health services for Veterans but have other mental health providers capable of providing high quality services; the willingness and capability of these entities for providing outreach and treatment services for returning Veterans; the feasibility of developing performance based contracts with these entities that meet the requirement of Section 107; and the use of services and the outcomes of care provided through these contracts.

Section 403 requires VA to conduct a pilot program that would provide non-VA care for highly rural enrolled veterans in five VISNs. VA is working to implement this pilot while resolving two questions. First, VA must develop a regulation to define the "hardship provision" in Section 403(b)(2)(B). Second, we must reconcile how VA has traditionally defined "highly rural" (based on Census data as discussed above) and how the statute defines it. VA's next steps involve identifying qualifying communities, identifying local providers willing and able to participate, and beginning with acquisition and exchanges of medical information as well as addressing pharmacy benefits and performance criteria for contracts and care.

HEALTH CARE PROVIDERS

Everyday, almost 60 million Americans in rural and highly rural areas face numerous challenges regarding health care, but one of the most significant in this area is a shortage of providers—particularly specialty providers. Recruitment and retention of health care professionals in rural areas is a national problem, not a VA-specific problem. However, VA is working diligently to develop and implement creative solutions that will provide incentives and opportunities to bring qualified health care providers to these areas.

For example, we are currently one year into a three-year pilot program for VA's Travel Nurse Corps. This program was created in response to a nationwide shortage of nurses and places nurses in medical centers and clinics across the country on a temporary basis. These nurses reduce wait times and the reliance upon contractors while bringing with them high-skill services and valuable knowledge of procedures. The program is designed to improve recruitment, decrease turnover and maintain high standards of patient care. Nurses are compensated for their time on duty and their travel, while also receiving per diem allowances, making it competitive with the private sector. The Travel Nurse Corps has the added benefit of establishing a potential pool of skilled and experienced nurses capable of responding in the event of a national emergency.

One key incentive VA offers is the Education Debt Reduction Program, which provides for reimbursement of payments made to recently appointed Title 38 and Hybrid Title 38 employees on qualifying educational loans. The maximum award amount is $52,298 (as adjusted) over a total of five years of participation, but it carries an added value because of the tax exempt status of the award. As of January 2009, there were over 7,500 health care professionals participating in EDRP. The average amount authorized per student, for all years, is $19,596. While employees from 34 occupations participate in the program, 75 percent are from three mission critical occupations—registered nurse, pharmacist, and physician. Resignation rates of EDRP recipients are significantly less than non-recipients. The EDRP incentive may be used in addition to other Federal incentives such as the recruitment incentive (hiring bonus), relocation incentive, or retention incentive—as hiring priorities dictate. While not exclusively used to recruit in rural areas, VA authorized over $66 million for non-EDRP hiring incentives for employees in Title 38 occupations. The recipients included physicians, nurses, and others. In each category, 93 to 95 percent of the funding was authorized for nurses and physicians as follows:

Recruitment (29%)	*Relocation (5%)*	*Retention (66%)*
Physicians – 27% Registered Nurses – 66%	Physicians – 72% Registered Nurses – 23%	Physicians – 27% Registered Nurses – 66%

From a recruiting perspective, VA is expanding the use of internet-based venues for health care related job postings in addition to recruiting from the VA job board, USAJobs.gov, and other niche job boards. The VHA Healthcare Retention & Recruitment office is hiring recruiters who will focus on recruitment of health care providers for rural areas and as well as establishing a national contract for retained search firms targeting physician recruitment. They are also developing collaborative relationships with organizations focused on rural recruitment such as the National Rural Recruitment & Retention Network (www.3Rnet.org), increasing training courses specifically for practices related to rural recruitment issues, and hiring recruiters whose primary focus will be recruitment of physicians.

More than 100,000 health professions trainees come to VA facilities each year for clinical learning experiences. Many of these trainees are near the end of their education or training programs and become a substantial recruitment pool for VA employment as health professionals. The annual VHA Learners' Perceptions Survey shows that, overall, following completion of VA learning experiences, trainees were twice as likely to consider VA employment as before the experience. This demonstrates that many trainees were not aware of VA employment opportunities or the quality of VA's healthcare environment prior to VA training but became considerably more interested after VA clinical experiences.

In an effort to initiate proactive strategies to aid in the shortage of clinical faculty, VA launched the VA Nursing Academy to address the nationwide shortage of nurses. The purpose of the Academy is to expand the number of nursing faculty in the schools, increase student nursing enrollment by 1,000 students, increase the number of students who come to VA for their clinical learning experience, and promote innovations in nursing education and clinical practice. Four partnerships were

established for the 2007–2008 school year. Six additional partnerships were selected in 2008.

Both a recruitment and retention tool, the Employee Incentive Scholarship Program (EISP) pays up to $35,900 for academic health care related degree programs. The average scholarship awarded is $12,392 for the duration of the academic program. Since the program began in 1999, approximately 7200 VA employees have received scholarship awards for academic education programs related to Title 38 and Hybrid Title 38 occupations. Over 4000 employees have graduated from their academic programs thus far; many are still in progress. Scholarship recipients include registered nurses (93 percent), pharmacists, and many other allied health professionals. Focus group market research shows that staff education programs offered by VHA are considered a major factor in individuals selecting VA as their choice of employer. A five year analysis of program outcomes demonstrated positive employee retention. Less than one percent of nurses leave VHA during their service obligation period (from one to three years after completion of degree). As of October 28, 2008, scholarship funding for this program since 1999 through FY 2012 is $88.3 million. This figure includes future funds for those who have received scholarships for academic years extending through 2012.

The implementation of the physician pay statute (Public Law 108–445) has been very successful for VHA. The pay of VHA physicians and dentists consists of three elements: base pay, market pay, and performance pay. Between the implementation of the pay bill and the beginning of February 2009, we have increased the number of VA physicians by over 2,748.3 full time employee equivalents. This statutory authority has helped VHA's ability to recruit physicians and dentists. Additionally, section 5 of Public Law 108–445 authorizes the Chief Nurse of VHA to set Nurse Executive Pay to ensure we continue to successfully recruit and retain nursing leaders.

CONCLUSION

Mr. Chairman, VA's Office of Rural Health is reaching across the Department to coordinate and support programs aimed at increasing access for Veterans in rural and highly rural communities. We work closely with the Office of Care Coordination and our colleague, Dr. Darkins, in this regard and it is our pleasure to sit with him before you today. Thank you once again for the opportunity to discuss VA's continuing efforts for rural Veterans. We are prepared to address any additional questions you might have.

Chairman AKAKA. Thank you. Thank you very much, Ms. Hawthorne.

Now we will hear from Dr. Darkins.

STATEMENT OF ADAM DARKINS, M.D., CHIEF CONSULTANT FOR CARE COORDINATION, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. DARKINS. Aloha, Mr. Chairman. Thank you very much for the opportunity to be here and to the Committee for highlighting the issues related to delivering care to veterans in rural areas. It is a privilege to work for the VA, to be involved in addressing those problems, and using telehealth to do so.

I would like to request that my written statement be submitted for the record.

Chairman AKAKA. It will be included in the record.

Dr. DARKINS. Thank you.

Telehealth uses information and telecommunications technologies to support clinical care where a patient and practitioner are separated by geographical distance. It increases access to specialist services and reduces both patient and provider's travel, thereby reducing one of the major barriers to care in rural areas, where recruiting of health care professionals can be problematic.

However, I should just say at the beginning that telehealth is not a panacea in the sense that there are obligate needs for face-to-face delivery of services, and telehealth has to fit into a spectrum of ap-

propriate care requirements in any particular locality. But it can fit into that when the requirements are met for safe, effective, and efficient care when we address the clinical technology and also the business processes associated with telehealth.

The cost and complexity of managing chronic disease in rural areas challenges all health care organizations—hence, telehealth's focus on these conditions in VA. VA's vision for telehealth is providing veteran patients with the right care in the right place and at the right time. The VA goal is to make the home the preferred place of care wherever this is possible to do so. And in order to achieve this, VA has established three enterprise-wide telehealth programs that serve veterans in urban, rural, and in highly rural locations, as well as the special circumstances of addressing the challenges for American Indian/Alaskan Native, Hawaiian Native, and Pacific Islander communities. VA has seven telehealth programs supporting these various communities, and further deployments are in progress to serve 15 more tribes.

The first enterprise program that I would like to cover is Care Coordination/Home Telehealth, or CCHT. This uses a national VA telehealth technology platform that collects vital sign data, disease management responses, and conducts video consultations into the home. This platform supports standardized clinical processes that care currently for 36,400 veteran patients, 20,000 of whom are receiving non-institutional care. Thirty-eight percent of these patients are in rural areas and 2 percent are in highly rural areas—proportions that show no urban bias in the deployment of this technology. CCHT data shows a 25-percent reduction in hospital stays and a 19-percent reduction in hospital admissions with CCHT, 50-percent reduction in highly rural areas, and a 17 percent in rural areas associated with the use of this telehealth technology. These services are provided from 140 VA medical facilities and 28 rural or highly rural clinics.

The second program I want to mention is Care Coordination/General Telehealth. It is another enterprise program that uses clinical videoconferencing systems to deliver services between VA medical centers and community-based outpatient clinics. In fiscal year 2008, over 48,000 veterans received these services, covering 35 clinical specialties, mainly mental health, of which 29,000 received this care. These services are provided to 171 sites in rural or highly rural areas.

Patients receive their tele-mental health care as part of VA's mental health universal service care plan, which is certainly addressing a focus on primary care—to deliver these services and the importance of increasing this. And they have shown a 24.6-percent reduction in hospital admissions and a 24.4-percent reduction in bed days of care, which is really associated with people receiving care more rapidly and thereby reducing the need for travel to care.

VA established a Polytrauma Telehealth Network in fiscal year 2007 which connects VA's polytrauma sites of care and links them back also to Walter Reed Army Medical Center and Bethesda Naval Hospital. In fiscal year 2009, we are planning to expand this network into a national infrastructure, which we are calling the Clinical Enterprise Videoconference Network. The intent of this is

ultimately to lead to any site being able to connect to any other VA clinical site for the delivery of care.

We are also establishing a national tele-mental health center for the delivery of specialist mental health services via this network, and we will seek to address particularly issues in rural delivery of care.

The third enterprise program I want to mention is that of Care Coordination/Store-and-Forwards. It involves capture and storage of digital images from patients' and their transmission to health care providers to report. Twenty percent of the veteran patient population receiving health care has diabetes, and this program screens for diabetic eye disease. Last year, 98,000 veteran patients received this care and it helped prevent avoidable blindness by doing so. In addition to this, we are expanding care in the area of CCSF into areas of tele-dermatology.

VA is training staff to use telehealth technologies and to ensure their adherence to the associated clinical and business processes. We have three designated telehealth training centers: one in Lake City, Florida; a second in Salt Lake City, Utah; and a third which is in Boston, Massachusetts. These centers have trained over 6,000 staff to provide VA with a tele-mental health competent workforce. The associated training curricula are standardized and utilize virtual training modalities wherever possible.

VA has an internal system in place to assess the quality and consistency of its telehealth programs that is conducted biannually in each one of the VISNs. A fundamental underpinning for all areas of telehealth we are implementing is the use of our VA electronic health record.

In closing, I would like to recognize the VA staff that develops these groundbreaking services. Our staff is driven by a commitment to support independence of the veterans we serve in all locations by providing access to high-quality care. The successful marriage of people and technology that I have just described is enabling VA to sustain a rapid pace of telehealth expansion and makes us a recognized leader in the field.

Mr. Chairman, that concludes my prepared statement. I would like to take the opportunity to demonstrate this technology to you at an appropriate future time, and I am now pleased to answer any questions that you may have.

[The prepared statement of Dr. Darkins follows:]

PREPARED STATEMENT OF ADAM DARKINS, MD, CHIEF CONSULTANT, CARE COORDINATION OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Good morning, Mr. Chairman. I appreciate the interest of the Committee in the Department of Veterans Affairs' (VA's) telehealth programs and welcome the opportunity to brief you on their current status. Telehealth involves the use of information and telecommunications technologies to deliver services in situations in which patient and health care provider are separated by geographical distance. The benefits to Veteran patients that accrue from VA's implementation of telehealth include increasing access to specialist care and reducing travel times for patients and health care providers. These benefits make telehealth of particular relevance to service delivery in rural areas where recruitment of health care providers can be problematic for all health care organizations, not just VA. Telehealth also reduces the need for travel which can be costly, inconvenient and may act as a barrier to care.

In this context, it is important to note that telehealth is not a panacea that addresses all the challenges of health care delivery in rural areas. There is a real need

for face-to-face services in many instances. Therefore, given the necessary clinical, technological and business processes that underpin safe, effective and efficient care, telehealth services fit into a continuum of appropriate services for meeting the health care needs of the enrolled Veteran population.

VA is predominantly targeting chronic disease in the Veteran population through our telehealth programs. Care of patients with chronic disease is a major challenge that all health care organizations face and which telehealth can help address. VA's vision for telehealth is to provide the right care in the right place at the right time with a goal of making the home and local community the preferred place of care when it is possible and when it is the Veteran's preference. In pursuit of this goal, VA has implemented three large, standardized telehealth programs that are available for urban, rural and highly rural Veterans. VA's telehealth programs also extend to American Indian/Alaskan Native, Native Hawaiian, and Pacific Island Insular Area communities. VA currently operates seven such programs that include Hawaii and the Pacific Island Insular Area and Alaska. Four more await connectivity and 11 others are in various stages of deployment for 15 Tribes in the continental United States.

The first major program is Care Coordination/Home Telehealth (CCHT). This program uses telehealth devices to connect enrolled Veterans with a VA practitioner, usually a nurse or social worker, who can routinely monitor vital sign data, disease management responses and engage in video consultations. VA has implemented a national technology platform to support standardized clinical and business processes. Through the adoption of this systematic approach to CCHT, VA has built a program that provides care to 36,400 patients, 20,000 of whom are receiving non-institutional care. Thirty eight percent of CCHT patients in VA are in rural areas and two percent are in highly rural areas. These proportions of rural and non-rural patients mirror the proportions in the Veteran population as a whole. This is important because CCHT is equally useful and available in rural and urban settings. Routine clinical outcomes data from VA's CCHT program published in December 2008 showed an 25 percent reduction in the average number of days patients enrolled in CCHT are hospitalized and a 19 percent reduction in hospital admissions. The data also reveal a 17 percent reduction in hospital admissions for rural Veterans using CCHT and a 50 percent reduction for highly rural Veterans. Currently over 140 VA medical centers provide CCHT in addition to 28 CCHT clinics located in rural and highly rural areas.

The second major area of telehealth in VA is Care Coordination/General Telehealth (CCGT), which uses real-time clinical videoconferencing systems to deliver services between VA medical centers (VAMCs) and community-based outpatient clinics (CBOCs) over VA's telecommunications networks. In Fiscal Year (FY) 2008, more than 48,000 Veterans received care nationally through this program. Over 35 clinical specialties in VA participate in the delivery of services via CCGT. CCGT mainly addresses care related to mental health and rehabilitation. In FY 2008, VA provided mental health care to 29,000 Veterans through tele-mental health. Patients received care at 171 sites in rural or highly rural areas. Tele-mental health is part of the overall framework of the mental health universal service plan. Routine outcomes data for tele-mental health in VHA have shown a 24.6 percent reduction in hospital admissions and 24.4 percent reduction in bed days of care.

In FY 2007 VA implemented a Polytrauma Telehealth Network to link VA's sites of care for polytrauma patients and offers CCGT tele-rehabilitation services and provide access to Walter Reed Army Medical Center and Bethesda Naval Hospital. In FY 2009, VA is seeking to extend this concept of networked services further by developing a national CCGT technology infrastructure called the Clinical Enterprise Video-conferencing Network. This Fiscal Year VA plans to establish a national telemental health center to coordinate delivery of specialist mental health services via tele-mental health for conditions such as bipolar disorder and Post Traumatic Stress Disorder. Part of this initiative will focus on delivery of these services in rural areas.

The final major area of telehealth is Care Coordination/Store-and-Forwards (CCSF), which involves the capture and storage of digital images that are transmitted to a remote location where a health care provider can report the image and return it to the patient site for use in the diagnosis and management of various conditions. VA's most significant advances in this area involve screening Veterans for diabetic eye disease. Twenty percent of the Veteran patient population has diabetes. Screening for diabetic eye disease is important because if it is recognized and treated before complications arise, we can prevent avoidable blindness. In other specialty areas, VA made tele-retinal imaging services available to 98,000 Veterans last year and 54 of the 219 sites at which this care took place were in rural or highly rural clinics. The remainder of the CCSF was for was tele-dermatology. Currently VA is

working toward a standardized approach to tele-dermatology with the intent of future enterprise-wide adoption.

Training is an essential component of any successful new technology or service. VA staff is trained to use CCHT technology and adhere to clinical and business processes through courses developed and instituted by a VA home telehealth training center in Lake City, Florida. This training draws, wherever possible, on technologies that enable virtual participation. VA has a training center for CCGT in Salt Lake City, Utah and a CCSF training center in Boston, Massachusetts. Training center curricula are standardized and we emphasize virtual training whenever practical and possible. The three VA telehealth training centers have enabled over 6,000 staff to be trained and have helped sustain a rapid pace of telehealth expansion that makes VA a recognized national leader in the field of telehealth. VA has also implemented an internal system to assess the quality and consistency of its telehealth programs at a VISN level that is conducted in each VISN biannually.

In conclusion I would like to recognize the dedication of staff throughout VA in developing these ground-breaking services. Their energy and enthusiasm supports the independence of the Veterans we serve by providing access to high quality care via telehealth. Fundamental to our success is VA's electronic health record system. Without an electronic health record, telehealth systems are of limited benefit because without clinical information, laboratory results and clinical images, it is impossible to change the location of care and proactively address many health issues.

Mr. Chairman, this concludes my prepared statement. I would like to take this opportunity to offer my services to you to demonstrate this technology at a future time. I would be pleased to answer any questions you may have.

Senator MURRAY [presiding]. Thank you very much to both of you for your testimony. We do have Members coming back and forth. I will ask a couple questions and turn it over to Senator Burr.

I think you talked a lot about the importance of telehealth, but I was very disappointed to learn from the staff of this Committee that telehealth use is actually decreasing in some rural communities, and a lot of that is attributed to lack of space or trained personnel. Can you comment, Dr. Darkins, on how the VA is overseeing these programs so that they are utilized?

Dr. DARKINS. Certainly, bringing these programs together depends on having the clinical staff. It also requires the facilities and the telecommunications bandwidth to do it. We are expanding these enterprise programs and as we do so, we have to make sure that these requirements are taken into consideration.

The enterprise programs that we are rolling out are taking over, in many cases, previous pilot programs that did not have this kind of infrastructure to back them.

Senator MURRAY. Do you have the resources to do this?

Dr. DARKINS. I believe there are. These decisions about using telehealth service provision are made at a local level, and what we are seeing is transition of services which were previously delivered face-to-face toward ones that are now are using telehealth to deliver services. These decisions are made very much at a local level in bringing those requirements together.

Senator MURRAY. I am told that a lot of the health care providers who use telemedicine to deliver telehealth have to be credentialed and privileged at each and every facility that gets the care as well as at the site that the provider provides the service. Can you help me understand whether this credentialing or servicing presents a challenge to our ability to——

Dr. DARKINS. It certainly does so. It does for us in VA as it does for all health care organizations providing telehealth services. State licensure for a VA practitioner in any State allows them to cross State lines, which is a benefit we have above those in private

sector organizations. However, one of the requirements that we as all providers face is that staff need to be credentialed at sites delivering care, and in many cases have to be privileged.

Senator MURRAY. So this is a real challenge.

Dr. DARKINS. It is a challenge because there is an administrative burden, particularly in some of those rural sites, where there may be quite a turnover of staff. And we are seeking ways that we can address this actively because of the burden to delivering services.

Senator MURRAY. All right. And then very quickly—and I have to leave to vote—Ms. Hawthorne, the VA IG's May 2007 assessment of VHA's Suicide Prevention Initiative said that some of the data suggested that we are seeing higher suicide rates in rural areas. Are we seeing that among the veterans population as well?

Ms. HAWTHORNE. I am not the expert in this subject matter area, so I would like to take that question for the record so I could provide you a more accurate reply.

Senator MURRAY. If you could, because I am concerned about whether or not that is accurate; and if it is, what we are doing to provide outreach and better access for our servicemembers in more rural areas.

[The information requested follows:]

RESPONSE TO QUESTIONS ARISING DURING THE HEARING BY HON. PATTY MURRAY TO KARA HAWTHORNE, DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION

Question. What is the rate of suicides for rural Veterans compared to non-rural Veterans?

Response. The rates of suicide were 39.7/100,000 person years for patients whose last VA use (in FY05 or FY06) was at a facility in a rural area (based on classifications from the Office of Rural Health) and 35.0/100,000 person years for patients in urban areas.

Senator MURRAY. I am going to turn it over to Senator Burr for his questions, and thank you very much.

Senator BURR. Thanks, Senator Murray. I am only going to ask one, and then I am going to turn it to Senator Tester, and I am going to go vote, and I will save the majority of my time for when I come back. I just want to try to clarify a question you were asked and how you answered. It dealt with the credentialing issue. Credentialing, as I understand it, is one's ability to practice a particular specialty. Am I correct?

Dr. DARKINS. Credentialing verifies that the qualifications a practitioner requires to practice in a clinical area are indeed the qualifications that they have. So it is a way to check their licensure, their professional training.

Senator BURR. But we do not——

Dr. DARKINS. Telemedicine in the private sector outside VA requires a license in every State a practitioner delivers care to.

VA does not have a licensing issue in terms of needing a license in every State where telehealth is delivered. However, one of the things I ought to point out is that it is important to ensure that a practitioner is indeed licensed and qualified to provide the services required. Credentialing is the process that makes sure that the person is appropriately qualified and licensed and ensures the patient that the person they see for care is qualified and competent to deliver the care.

VA has a national system called VetPro, which is very beneficial. So credentialing is less of a problem for us.

Senator BURR. I will get into more of this when I get back. I am going to turn it over to the Chairman now.

Chairman AKAKA [presiding]. Senator Tester?

Senator TESTER. Yes, thank you, Mr. Chairman. I apologize for not being able to hear all of your testimony. I think I got most of yours, Ms. Hawthorne, and if questions were asked previously along the same lines I am asking, I apologize ahead of time.

As I was reading over your testimony, Ms. Hawthorne, you said that highly rural areas are seven people per square mile or less, and that 2 percent of veterans live in those kind of areas. Did you do anything differently for folks that live in the highly rural areas—and that question could go to either one of you—over folks who live in rural areas or urban areas?

Ms. HAWTHORNE. Veterans who live in highly rural areas obviously have some unique challenges that neither their urban nor rural counterparts have. So, as far as delivery of care, we are looking at specific ways that we can increase that, and we will be leveraging some of the same service modes, such as telehealth. And we are also looking at partnering with our community providers to see if this is an appropriate way to expand care in those highly-rural areas, as well as utilizing mobile clinics. Could this be another opportunity to get into those more remote and highly rural areas? And then outreach clinics are a little less feasible, but, again, by partnering with our community providers, we may be able to expand access in that way as well.

Senator TESTER. Have you started those endeavors yet as far as partnering up with folks? Is that actually happening in the highly rural areas yet?

Ms. HAWTHORNE. We have initiated a pilot project for mobile vans and have four. One is currently operational; as for the other three, they have purchased the equipment and hope to be within operation in a few months.

As far as partnering with the communities, we are actively engaged in seeking out ways to do this. We recognize, though, that continuity of care is very important. So before we move forward, we want to address all the quality issues, ensure that we are measuring properly, so that we can make a determination that our veterans are receiving the highest quality of care.

Senator TESTER. OK. Speaking from a mental health perspective, in rural or highly rural areas, for instance, in eastern Montana, right now I do not think we have a mental health professional east of Billings, Montana, and there are several hundred miles east of Billings, Montana, before you hit the North Dakota line.

If you partner with primary care settings and it is a mental health issue, how is that handled?

Ms. HAWTHORNE. If I could first share with you that my background is of a clinical social worker, so I am very aware of mental health issues. I have directly worked with the mental health population.

Senator TESTER. That is good.

Ms. HAWTHORNE. And, again, continuity of care is extremely important—even more so in this case. So if we work with non-VA pro-

viders, we have to have to ensure that the VA clinicians are getting their medical records and that there is proper case management following up with their care, and that we monitor the control points to ensure that if care is exasperated and the veteran needs a higher level of care, that we have in place a method to ensure that that happens.

Senator TESTER. I do not have an answer to this question. Most questions you ask you have an answer for, but I do not. If you have got a situation where the nearest mental health professional is several hours away—maybe as far as 8 hours away—and you have got a person that is ready to commit suicide; they have called the hotline, and there is no doubt about it, we have got a problem. How is that handled? Either one of you can speak to that. That would be fine with me.

Ms. HAWTHORNE. I will have to take that question for the record because our Office of Mental Health Services is actually coordinating the suicide prevention hotline, and I am sure that they have some things in place that would address that question.

Senator TESTER. OK.

[The information requested follows:]

RESPONSE TO QUESTIONS ARISING DURING THE HEARING BY HON. JON TESTER TO KARA HAWTHORNE, DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION

Question. How would VA handle a suicidal Veteran in a rural area who is acute and needs help today?

Response. VA's response to Veterans with suicidal risk is to intervene as necessary to support safety, whether the veteran is in an urban, rural, or highly rural area. When Veterans call the VA Suicide Prevention Hotline, they are evaluated for risk by clinician-responders in the call center. If they are found to be at imminent risk, the responders call police, ambulances or other emergency personnel who can make contact with the caller as soon as possible, and arrange for hospitalization as needed. Since the time the Hotline was established, there have been over 2,600 rescues of this type. Other Veterans may speak with providers at VA facilities, rather than the Hotline. However, the response is the same, emphasizing rapid access to care for those who are at imminent risk, regardless of where they live.

Dr. DARKINS. Again, I think obviously it depends, services being local, exactly what—for the particular situation. But as an extreme urgency for the VA—as you know, everything the VA is currently doing is very much aimed at mental health services toward addressing those kinds of issues. From my particular remit, I can give you the issues around the use of tele-mental health, which, as I say, is not a panacea. In some sense, in some cases, it is possible to use telehealth for those kind of urgent interventions. It is also possible to use telehealth directly in the home to be able to obviate people getting into that circumstance.

Connection with local services and the ability to access local—so telehealth fits into those wide areas of care. And the VA's universal service plan for mental health, other work in mental health is certainly aimed at addressing those issues.

From my point of view and my particular expertise, telehealth can lend a hand, can be useful in some of those circumstances, and certainly is part of that continuum of services that needs to be provided to help that person in that kind of distress.

Senator TESTER. All right. I know the VA has been hiring a bunch of folks to deal with mental health issues, to the point

where—I actually talked to some folks in the private sector, saying they cannot hire anybody because the VA is hiring them all. And I commend them on that, you know, making a solid attempt to address that.

Are there incentives offered to get them into rural America, into highly rural areas? Because that also is a big issue. And the conundrum is—as you are talking about, only 2 percent of the vets are living in the highly rural areas, which means 98 percent live somewhere else. How big of a priority is it to get mental health professionals into those areas and are there incentives?

Ms. HAWTHORNE. Getting providers into rural areas is one of the primary focuses of the Office of Rural Health and part of our core initiatives. So we are working very closely with the VHA program offices that oversee this. We do offer an education debt reduction and other services currently, and we are initiating some new, innovative recruiting methods as well. Specifically, 3RNet seeks rural providers, and we have teamed up with them.

Also, the Office of Rural Health is working with our Office of Academic Affiliations, and we are looking at how we can expand physician residency into rural areas, knowing that when providers train in rural areas, they are more likely to stay in rural areas.

Senator TESTER. What about the highly rural areas? Are we doing anything different from rural areas as far as getting people into them?

Ms. HAWTHORNE. Not specifically at this time.

Senator TESTER. Do you think there should be something done?

Ms. HAWTHORNE. I cannot answer that directly right now. I think they are two very tough populations. It is even more difficult in the highly rural areas because you are less likely to have the academic affiliations and the resources to——

Senator TESTER. Thank you very much. I will check off. If there is another round, I have got some more questions. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Tester.

Senator Begich?

Senator BEGICH. Thank you very much, Mr. Chairman; and I apologize, we had to slip out. But I am looking at the testimony—Dr. Darkins, I think this is from you—in regards to the VA telehealth programs extended, and you talk about the Indian/Alaska Native community, the Hawaiian community, Alaska. Can you just expand a little bit on that? Then I have some specific questions. But can you expand on how you see that working or how that has been working, and what kind of volume of response? I am not sure who could answer that, but I saw it in your testimony, so I would look to both of you.

Dr. DARKINS. Yes, I can certainly address that. There are telehealth programs in both Alaska and in Hawaii and serving the islands as well. The three enterprise programs I mentioned are all present there.

There is the home telehealth programs. I think on the order of 230 patients are currently being served for home telehealth out of Anchorage. So, it has become established. We also have teleretinal imaging which is taking place in Anchorage, plus the telehealth real-time videoconferencing that is taking place.

There are close associations between the VA and the other Federal agencies through the Afghan Project, which is there to be able to provide access to multiple sites throughout Alaska.

We have variations around the country in terms of how telehealth is being implemented. We have enterprise systems, as I mentioned, which are readily available to implement. We are gradually rolling forward now.

One of the salutary things about technology is that it is very much in the end down to relationships, so what we are finding is extending the use of this technology is very much centered around relationships—relationships between individual clinicians and their patients, being comfortable on both sides doing it, but also the relationships between the Federal agencies and then working and partnering in this way of taking it forward.

So what I would like to say is I think that the infrastructure, the various components are there to do this. Moving it forward is very much a sense of that organizational change. But as we are seeing, I certainly look back over these last 2–3 years, of what has been happening in Alaska with the home telehealth, what has been happening with the teleretinal imaging, and I am seeing pleasing increases in the results with patients and would hope to look forward to that being even more rapid.

If there are any suggestions either from yourself or other Members of the Committee of things that we can do to address your population or for the population of the Hawaiian Islands, then that is certainly a huge priority for us. Given what we are addressing, given what we have heard of returning military, to go the extra mile to be able to serve those people, we will do anything that is necessary.

Senator BEGICH. Great, because as we talk about rural, you know, and you talk about drive miles, they are not drive miles in Alaska. That is why in your comment that you said about mileage versus how many miles away by road, you know, we measure by air because that is how we can get to locations. And then telemedicine in Alaska—education through technology and others has been pioneered in a lot of ways in Alaska because of the uniqueness of it; in rural communities especially, where you may have a hub that you can fly to, but you may have a village you cannot get to because of weather conditions, as well as many other factors. I absolutely will look at some ideas we would like to pass on to you.

I do not know which of you would answer this, but in regards to the extensive Native medical care system that we have in Alaska, that is continuing to be developed, and we announced Monday there will be a facility in Nome, Alaska, about a $150 million facility starting construction this year, again, offering enormous quality health care. I know you have a couple of partnerships you are in the midst of trying to develop, and there is some lag time on that, but it just seems so logical. Senator Tester and I have talked about this when I had him up to Alaska, that is, to allow these veterans—because we do not have a VA hospital in Alaska—why not just allow the veterans to utilize the services of any hub medical facility—in this case, Native Hospital, which is run by a consortium of Native tribes, but also is funded by a Federal agency anyway. It is all Federal money. So, why not figure out a way that that sys-

tem can be utilized much more aggressively than just a couple of pilot programs, to just use them and then have VA reimburse.

I know there is an argument that, well, VA does not have a budget line for that, and then there is this other argument. But building a hospital would be a huge expense, and yet we have these beautiful hospitals and clinics being built all throughout Alaska.

I do not know who can answer that, and I know there are one or two—I cannot remember which ones right off the bat, but—pilots that you are looking at. But it just seems for an Alaskan veteran who lives in a village like Kwethluk and has to spend $1,500 in airline tickets to get to a location and then know they have to go back there is not a very good way to deliver health care.

Dr. DARKINS. Soon after I joined the VA, I went to Alaska. I went to Bethel and I went up river; actually saw the——

Senator BEGICH. Did you go in an open boat? That is the way to go.

Dr. DARKINS. I did. I went in an open boat, yes.

Senator BEGICH. That was the test. They tested you. Very good.

Dr. DARKINS. And the boatmen, when they came back——

[Laughter.]

Senator BEGICH. That is the test. He survived. Good.

Dr. DARKINS. When the boatmen came back, they took us for some salmon strips in the shed. But it was possible to see exactly as you describe the tremendous health needs throughout, and I was enormously impressed to see how locally it is possible to deliver through the health aides the care that is taking place.

There are already, I know, really good relationships for certain services between the VA, the DOD, and the Indian Health Service where they do share relationships. Senator Burris mentioned in North Chicago the relationship that is taking place there and how that is growing. So I think there are models of both how it is being done, and I think things like North Chicago show the way forward for how it can be done further.

It is somewhat outside my remit or my piece of the world to be able to say overall, but I think certainly there is encouragement in ways in which, exactly as you say, it is going forward, and it is a very high priority for VA.

Senator BEGICH. Very good. Thank you.

Ms. Hawthorne, did you have anything?

Ms. HAWTHORNE. I would like to follow by saying we also recognize that leveraging our community partners and the infrastructure already in rural areas is a direction that we do need to consider.

I would like to point out that our Veterans Rural Health Resource Center, based out of Salt Lake City, has developed infrastructure to specifically look at these populations; and we are looking at it from a policy perspective and also testing out ideas. So we have some pilots and those are going well, and we hope to take those pilots that are successful and distribute eventually them through the larger health care system.

Senator BEGICH. Very good. I will leave it at that for now, Mr. Chairman. Thank you very much.

Chairman AKAKA. Thank you very much.

Now let me call on Senator Burris for his questions.

Senator BURRIS. Thank you, Mr. Chairman.

Dr. Darkins, how does telehealth facilitate the care if an issue is discovered in the teleconsultation that requires a veteran to seek direct care? How does that telecare operate?

Dr. DARKINS. It addresses a lot—there are two pieces to delivery of health care. There is a direct delivery of care itself, which is often hands-on in terms of being able to intervene, to be able to diagnose, to be face to face with a patient. The second piece is to be able to make sure the right patient has got to the right place at the right time. So there is a piece about health care decisionmaking and then the actions associated with it.

What telehealth can do is to make sure that those health care decisions can be made as close to the patient as possible, so let me give you a hypothetical case.

You have the situation where somebody has had a stroke. Having had a stroke, the issue is what should be done. What kind of urgent treatment might be used to be able to help that person and make sure that they get the maximum chance of success and survival? So the ability of telehealth is to be able to take a specialist who might be elsewhere and to be able to help address in primary care or even in a smaller community hospital, so you can get absolute special expertise right to where that decision needs to take place. And often having that kind of decisionmaking in the acute stage can make the difference between life or death to somebody. So telehealth is something really beneficial even in the very acute stage.

We manage, as I said, 36,700 patients. I mentioned the reduction in travel times—sorry, the reduction in hospital admissions. What we are doing is instead of somebody who may have chronic heart failure having to come along to the hospital regularly for outpatient treatments—where there is the travel, there are the wait times, et cetera—what we are doing is monitoring them on a daily basis, so if they start to get into trouble, so if their weight starts to go up, if they start to get symptomatic, such as breathless——

Senator BURRIS. Or blood pressure going up, yes.

Dr. DARKINS [continuing]. Yes. What we can do is contact them. Usually a nurse will contact them by telephone, can adjust their medications under orders they have been given, and can actually prevent their deterioration.

So telehealth is very much about changing the location of decisionmaking, also trying to stop people from getting into trouble, supporting their own understanding of their own health care and self-management.

Senator BURRIS. Thank you very much.

Ms. Hawthorne, what are we doing to make community providers more willing to treat vets on a fee basis? I am aware that many vets are not being reimbursed and providers are only receiving a percentage of the payments. Can you help me out there?

Ms. HAWTHORNE. I cannot speak to specifics of the fee basis program, but can take that back for an answer.

Senator BURRIS. OK, please.

[The information requested follows:]

RESPONSE TO QUESTIONS ARISING DURING THE HEARING BY HON. ROLAND W. BURRIS TO KARA HAWTHORNE, DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION

Question. What are the fee basis rates for reimbursement in rural areas? Are they sufficient?

Response. In the absence of a formal contract or negotiated agreement, VA payment for acute inpatient care and outpatient professional, laboratory, and dialysis services is the same as the full Medicare reimbursement. In the absence of a Medicare rate, VA payment is based upon the usual and customary (U&C) billed charges. VA payment for non-acute inpatient care is based upon a cost-to-charge methodology determined by information provided to Medicare in the cost reports submitted by the hospitals. The cost-to-charge ratio is determined annually and the payment amount for non-acute inpatient care is determined by multiplying the billed charges by the ratio. Special payment rates are applied to facilities and providers in the state of Alaska due to scarce medical resource availability, and in the state of Maryland for institutional providers in receipt of waivers granted by Medicare.

Both Medicare and VA payment rates are geographically adjusted. The majority of payments based upon U&C charges are made using the 75th percentile methodology (8 highest billed charges received for the specified medical service the previous year ranked in order from highest to lowest). If there is not a 75th percentile rate available, VA payment for the service is the U&C charge. VA will pay the lesser of the above rate, the billed charge, or the amount negotiated with the provider via repricing agreement.

There is an exception to VA payment methodology for emergency care not previously authorized before services are rendered. Reimbursement for claims authorized under 38 U.S.C. 1725, which is the statutory authority used to pay for unauthorized emergency care provided to certain Veterans for the treatment of non-service-connected conditions, is reimbursed at the lesser of 70% of the applicable Medicare Fee Schedule or the amount the veteran is financially liable. A separate statutory authority is used to pay for unauthorized emergency care provided to certain service-connected Veterans; payment methodology used to pay for this care is the same as described above. Regardless of the statutory authority used for payment of unauthorized emergency care the payment is limited to the point of stabilization where the Veteran may be transferred to a VA or other Federal facility.

VA pays in a manner very similar to other payments community providers receive. VA is not aware of concerns raised by community providers on these payment rates.

Ms. HAWTHORNE. I would like to point out that the Office of Rural Health is looking at, though, when we engage in contracts, how we can best ensure that our providers are willing to work with us by making contracts amenable to both parties and ensuring that there are quality standards within those contracts.

Senator BURRIS. Because pretty soon even the rural doctors will not come to these communities because of the low ability to get any type of compensation. And then, if they cannot get compensated for their reasonable services, it is going to make it even harder for them to do it if they cannot even get paid on a fee basis.

Ms. HAWTHORNE. Correct.

Senator BURRIS. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burris.

A consistent question has been: are we meeting the needs of our veterans? VA is spending billions of dollars buying care in the community, and Congress appropriated another quarter billion dollars for specific rural health care and projects as well.

Given all of this effort and funding, my question to both of you: Are we meeting the needs of rural veterans? Ms. Hawthorne?

Ms. HAWTHORNE. Thank you. As I stated, increasing access to good quality health care is the focus of the Office of Rural Health and is how we will meet the needs. So I believe we are meeting the needs of our rural veterans. We, of course, can always improve and look to the Committee and to you, Mr. Chairman, for ideas on

how to do that. But for now we are proceeding to develop new innovative ideas that are going to address the uniqueness of the rural and the high rural populations, and we will continue to focus on that as we move forward.

Chairman AKAKA. Dr. Darkins?

Dr. DARKINS. From the perspective of the services I am responsible for—telehealth services—I believe we are. I believe we are on a trajectory to increasingly do so. My evidence for saying that really is the expansion that we are seeing in rural areas, seeing the home telehealth growth in rural areas, seeing the services delivering out to rural locations. Our plans are to expand this—both expand in terms of numbers, but also expand in terms of the breadth of it.

The delivery of specialist care, expanding that scope of specialist care delivery: I think, is something we can increasingly do more of. I think the needs of rural patients is something all health care organizations have problems with, and everybody could do more. I certainly believe in telehealth. With the developments we are making and the trajectory we're on, we will be able to increasingly meet the needs that you have addressed.

Chairman AKAKA. Yes. Well, there is no question telehealth services need to be expanded.

Dr. Darkins, in my State of Hawaii, we still have VA operations lacking telemedicine equipment, namely, on the island of Molokai. As you know, Hawaii has separate islands. Is this just an isolated instance, or are there other VA spots where the equipment has not been purchased?

Dr. DARKINS. There are certainly sites in the VA where there is no equipment currently. The equipment, as I mentioned before, is only part of the equation. So having the equipment does not guarantee the service is going to be provided. So the issues that we face as we roll out these programs around the country is the sites at which care has to take place must be private and have sufficient space for the patient to be able to have a consultation conducted with privacy and those concerns taken care of. There needs to be the telecommunications bandwidth.

Also, crucially, as I mentioned, it is about relationships. It really has to be that there are clinicians at the local sites and the services to be able to be provided.

So I can't—my apologies—comment on one individual site, but this tends to be the reason why we are not seeing necessarily something in every single site. Having equipment which is there but not functioning equally well is not what I would like to see either. My goal and what we are pushing toward is that we get all three pieces of this equation: the clinical service delivery, the right environment for the patient to be able to have the care, and the equipment to be able to do so.

Chairman AKAKA. Ms. Hawthorne, quality assurance is always a goal of VA. How can VA be sure that the non-VA doctors who see veterans in the community know how to treat combat-related illnesses like PTSD?

Ms. HAWTHORNE. I would like to address that first at the broader level. It is important for us to ensure that veterans receiving non-VA care are getting the top quality for all services. So when we

partner with non-VA providers, we are implementing a set of core quality measures that the VA is looking at. We are working with the Office of Quality and Performance to identify outcome measures so we will know specifically if they are providing adequate care or not based on these measures.

Regarding PTSD and other mental health services—likely the same with Office of Rural Health—the Office of Mental Health Services has specific outcome measures that they look at to ensure that care is being provided as the VA sees fit.

Chairman AKAKA. Thank you. I am going to start on a second round and ask Senator Burr for any more questions.

Senator BURR. Thank you, Mr. Chairman. I would just point out to the Chairman I cheated myself on the first round, so I may go over.

I want to go back to the telemedicine issue, doctor, just real quick for the purposes of trying to sort this out for all the Members.

The Asheville VA Hospital, as an example, services a population out of Tennessee. Today, if telemedicine is done out of Asheville and they monitor a Tennessee patient, that doctor, not licensed in Tennessee, licensed somewhere else, enters the VA system, has no trouble with providing that service in Tennessee, though he is physically in North Carolina. Correct?

Dr. DARKINS. From the point of legality, he or she can practice across State lines absolutely with their licensure. However, in order to do so, there are still requirements that regulatory bodies require. One of those requirements is that in Tennessee, it is necessary to check the credentials. So, in other words, to safeguard the patient, it is necessary to make sure that that physician who is in North Carolina indeed has his or her medical license, has got the professional training to be able to deliver those services. That is a requirement for VA, as other organizations.

In addition to that, there are two pieces to the competency of a clinician: first, is what you can do by virtue of your training; and, second, is that the environment is right to do it in.

So, to give you an example of a cardiac surgeon, somebody may be a fully licensed, professionally trained cardiac surgeon whose credentials are fully up to date and there is no issue with their practice. However, he or she would not be able to practice in a small hospital which did not have access to the necessary support to provide cardiac surgery. So that privilege is somebody at the site, so it is something related to the site.

Senator BURR. I agree. It is more of a privileging issue that you are talking about.

Dr. DARKINS. It is a privileging issue. So because of that privileging issue that relates back to the physical delivery of services, it is necessary for us to privilege at these various sites, and that is a considerable administrative burden in terms of establishing these services, particularly as we look toward what we would like to see in the future—establishing national services.

Let me give you the hypothetical example of a woman veteran who is pregnant who is on antipsychotic medication. The ability to be able to provide access to expertise that is very specialized is something that potentially could be done around the country. How-

ever, determining the site at which the person is going to be and the site it is going to be delivered and making sure all that privileging is done is a logistic issue I hope I have well enough described.

Senator BURR. You have, and it is the point I wanted to make for the Members. If we want the ideal, most efficient, highest quality of the delivery of care utilizing telemedicine, then we have got some barriers to overcome. And it should be of great interest to us to help try to facilitate that in a way that assures us of the high quality.

Let me, if I could, take the services provided in telemedicine and group three in a category: congestive heart failure, diabetes, and blood pressure monitoring. Share with me today, of the services we provide through telemedicine, what percentage do those three health conditions make up, and what makes up the rest?

Dr. DARKINS. I mentioned the three areas of health care delivery enterprise systems: the home telehealth; the videoconferencing between clinic and hospital; and the store, and, forward—the taking of digital images to share.

For the home telehealth, about two-thirds are taken up by the conditions that you mentioned. These are supporting people with chronic conditions in their own homes. It provides non-institutional care, is helping veterans live in their own homes who would otherwise potentially be in nursing home care. So, a very high focus on those high areas of need which are very expensive, as you know.

In terms of videoconferencing, the major areas we are doing videoconferencing between rural sites is mental health and rehabilitation. We are moving toward doing more in those areas of congestive heart failure, but our concentration has been much more in this proactive approach with home telehealth.

And I mentioned diabetes: 20 percent of the veteran population we serve has diabetes—who have seen the Veterans Health Administration—and so diabetic retinopathy screening, preventing avoidable blindness, is a very high priority.

So, mainly the home telehealth and the store and forward, but certainly an increasing amount we are going to see specialist care being delivered by these services as well.

Senator BURR. In your testimony on page 2, you said, "Currently over 140 VA medical centers provide"—telemedicine—"CCHT"——

Dr. DARKINS. Yes.

Senator BURR [continuing]. "In addition to 28 clinics located in rural and highly rural areas." Can I interpret that to mean that of those 28 clinics, they actually initiate the telehealth from that clinic, or are you referring to that clinic is a service point for one of the medical centers?

Dr. DARKINS. They initiate care from that clinic.

Senator BURR. So they would do home telehealth from that rural clinic.

Dr. DARKINS. They do.

Senator BURR. OK.

Dr. DARKINS. There is no requirement—sorry, the 140 medical centers I mentioned, they can deliver services hundreds of miles from the medical center. So, the fact that they are in VA medical centers does not mean, by any means, they are not delivering rural

services. There are logistic issues around issuing the technology, refurbishment of the technology, that make it easier at the moment to do so from a medical center. However, in terms of expanding these services, what we have been doing is looking toward also making them available from local clinics such as I mentioned.

In some instances, patients travel to the hospital or to the clinic to be enrolled in the program and get the technology. In other instances, the staff go out to the patients home. But certainly it is something that has been very pleasing for us to see what we thought was going to be more difficult, to go into clinic settings, has been rolling into the clinic settings in rural and highly rural areas, and something I am encouraging and want to push very much more for.

Senator BURR. Let me just turn to Ms. Hawthorne for one question. Last year's legislation that was enacted directed the VA to establish a pilot program for collaboration with non-VA providers to deliver health care services to veterans specifically in rural areas. Real quickly, are these programs fully underway? And what, if any, obstacles to timely implementation have we run into?

Ms. HAWTHORNE. Sure, good question. The Office of Rural Health has always had the vision to partner with community providers, so we welcome this piece of legislation to facilitate this.

We took swift action in developing an implementation plan to execute this pilot, and we will be ready to present that at the end of April. And we are still dealing with two technical issues right now. One is the statute's definition of "highly rural" differs from ours. And the second is a regulatory issue with the definition of "hardship." Once those two issues are resolved, I am going to be happy to work with the Chairman and the Committee Members on that, and we will be able to promptly move forward.

Senator BURR. Thank you very much.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Tester?

Senator TESTER. Real quick—just kind of dovetailing off of Senator Burr's question—in areas that you are going to contract with local communities, how do you envision accuracy of medical records when the health care is being provided by those local folks?

Ms. HAWTHORNE. When we identify the areas to specifically partner with, we will be working at the local level to execute this. So, the VISNs will help to identify the providers, and they will also be working to ensure that the medical records come back to the VA. And we will be asking them to use our electronic medical health records, and this will ensure the continuity of care and ensure that we do get a copy of the encounters.

Senator TESTER. As you implement this program, has there been any resistance from the hospital using the VA's medical records, the electronic version?

Ms. HAWTHORNE. At this point in our implementation, we have not contacted individual providers.

Senator TESTER. OK.

Senator BURR. Could I ask one question?

Senator TESTER. Sure.

Senator BURR. Where we have used non-VA contractors, which we currently do, part of the contracts, as I understand it, is a requirement that those records be supplied to the VA and electronically supplied. Am I right?

Ms. HAWTHORNE. Correct.

Senator BURR. So, currently that is in place where we are using contract care.

Senator TESTER. Yes. I just did not know if there was resistance to that. There should not be, but one never knows.

Senator BURR. It is part of the contract.

Senator TESTER. Right. Exactly.

One more question deals with mental health issues, and I guess the question is: Are there plans or how do you see us increasing mental health crisis beds to be available within a reasonable driving time? Or is that an issue you have talked about?

Ms. HAWTHORNE. Increasing the availability of mental health inpatient beds is not something that I have worked with the Office of Mental Health Services on, and so I will be happy to go back and address that question with them.

Senator TESTER. That would be good. All right. Thank you.

Thank you, Mr. Chairman.

[The information requested follows:]

RESPONSE TO QUESTIONS ARISING DURING THE HEARING BY HON. JON TESTER TO KARA HAWTHORNE, DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION

Question. What is the number of mental health beds available in rural areas? Are more needed?

Response. In FY 08, VA had 633 mental health beds in facilities operating in rural areas, and 4,088 mental health beds in facilities operating in urban areas.

Although the cumulative number of Veterans living in rural areas is high, the number living in any specific rural area is relatively low. The need for high intensity, low frequency health care services such as admission to an inpatient mental health unit is likely to be variable. From a clinical perspective, it would not be responsible to recommend any large scale increase in the number of VA mental health inpatient beds in rural areas. When a Veteran needs hospitalization for a mental disorder, it is important to arrange admission as soon as possible to a high quality facility that is staffed by clinicians with expertise in the Veterans' condition that can ensure continuity of care after discharge, and is accessible to the Veteran's family and support system. For Veterans living in rural areas, the best balance between these goals can be achieved by admission to the closest VA Medical Center. At other times, it can best be achieved by arranging for emergency admission to a local community-based facility. The best strategy is for individual, case-by-case evaluations.

Chairman AKAKA. Thank you, Senator Tester.

Now let me call on Senator Johanns for your questions.

STATEMENT OF HON. MIKE JOHANNS, U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Senator, thank you.

If I could just follow up on questions by Senator Burr. I have very high hopes for this pilot program, because there is, in some cases at least, capacity in some rural areas. And it just seems to me that it would be a natural.

But recognizing the difficulty of trying to match the VA system with that local hospital or medical provider in terms of the electronic system, how big of an impediment do you think that will be?

Because they cannot all have the system that would interconnect. And is that holding us back?

Ms. HAWTHORNE. I do not believe it is holding us back because we already do it.

Senator JOHANNS. OK.

Ms. HAWTHORNE. So there are methods for the non-VA providers to link into our system without having full access to the entire medical records.

So, to directly answer your question, no, I do not believe that will be an impediment, but it is something that we will, of course, have to address and be tracking.

Senator JOHANNS. Then if I might follow up on a question by Senator Tester, I appreciate his question about mental health services, because I suspect in his State they have identical problems as we do: just a lack of services in the rural areas, just in some rural areas a complete lack of services. It is hard to get a psychiatrist to go to rural areas, et cetera, et cetera.

Any idea on a novel approach? Because many veterans desperately need these services. They come home, they go back to the ranch or the farm, and all of a sudden things are falling apart for them. How do we deal with that?

Ms. HAWTHORNE. You have identified a very real problem, and we have done some analysis looking at highly rural areas, and what you stated is exactly the fact. There are not always the non-VA providers to even fee out to or contract with.

Senator JOHANNS. Right.

Ms. HAWTHORNE. So we are looking at—well, telehealth is obviously one of the major ways we are going to increase access to those veterans. We are also looking at other methods, such as using the telephone lines for care management. And we will have to be even more creative in identifying other methods and look to you if you have any ideas you would like to share.

Senator JOHANNS. I will just offer this thought: Telemedicine is a big resource here. It is an interesting thing. For example, on counseling services, people do not seem to be bothered communicating through that television set. And that offers at least the possibility to connect somebody in a very rural area with somebody in an urban area and, again, provide counseling services. I have seen it at work.

Many hospitals now do have telemedicine. Do you see an opportunity to contract into that hospital, for example, using their telemedicine services if we do not have those services out in the rural area?

Dr. DARKINS. Perhaps I could comment on that. Certainly, VA has very extensive experience in delivery of tele-mental health. The area you mentioned of counseling is extensively done throughout VA, not only in terms of individual counseling of patients, but as opposed to in terms of group counseling and group therapy, which is possible to do in locations. Also, treatment of PTSD, depression, and treatment of psychosis is all routinely done now. Not only is it done between hospital and smaller hospital, hospital and clinic, it is also being done directly into the patient's home. So the VA has a very extensive experience of that.

We are working very closely in terms of addressing these issues because telehealth can provide part of the solution, but what it has to do is to fit into how you crisis manage, how you fit into that wider spectrum of care. And, therefore, I work enormously closely with my colleague Dr. Katz in the Office of Mental Health Services.

VA has made incredible strides, I believe, over the last few years in terms of becoming, really, a model that other organization are looking to about the kinds of innovative approaches to delivering care that you have just mentioned. So, we have been looking toward how we move telehealth into rural areas; how we use it in the context of also physical bases of services.

You asked about doing it with other organizations. Yes, that is possible. There are difficulties in terms of not having a really robust contracting system for telehealth in the world outside. There are issues about exchange of health information. There are privacy issues in terms of linking onto networks, and there are just, again, those barriers to delivery of care, something which we are very well aware of working actively and hard to do. So it is really not for the want of either enthusiasm or wish, but just as we work through those details to make it happen. And, again, we would be very glad for any suggestions from either yourself or other Members of the Committee on how you think we might address this more.

Senator JOHANNS. I am out of time, but I will just wrap up with a suggestion. Having dealt with many of these issues as a Governor, one thing I would recommend—and I suspect you are doing it already—is to reach out to the Chief Medical Officer in the State. Every State has one. Some States have better public health networks than others, but that position is probably going to exist to some degree in every State, just simply because those personnel are traveling the same road you are. They are trying to figure this out, how do we get services out into rural areas, how do we deal with these very same issues. It could be a great partnership; certainly would be a resource that I would urge you to tap into. So thank you.

Chairman AKAKA. Thank you, Senator Johanns.

Senator JOHANNS. Thank you, Mr. Chairman.

Chairman AKAKA. Senator Burris, for any second-round questions?

Senator BURRIS. I am fine, Mr. Chairman. I am listening and learning. Thank you.

Chairman AKAKA. Thank you. We will submit our questions for the record and dismiss the first panel.

Thank you very much for your responses. You have been very helpful this morning.

Dr. DARKINS. Thank you very much.

[Questions from the Committee Members follow:]

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO KARA HAWTHORNE, DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION

CONTRACT/FEE-BASIS CARE

Question 1. Ms. Hawthorne, as you expand your partnership with local community providers through fee-basis and contracting, can you tell me how VA will be able to retain its quality control measures and continuity of care for which it has become well-known for?

Response. The Department of Veterans Affairs (VA) is committed to ensuring the highest possible quality of care for Veterans, regardless of how and where their care is delivered. This means care consistent with evidence-based practices and proper coordination to assure continuity.

VA would like to point out that such challenges are not easily met, in part because of well-recognized barriers to coordination in community practices.[1] Additionally, few community physicians have the infrastructure to electronically capture and report the clinical variables that VA relies on to ensure quality care.[2] Finally, unless a community site meets certain minimal volume thresholds (the statistical rule of thumb is approximately 30 unique cases per reporting period), performance metrics will have too great an error margin to be usable.

Recognizing these challenges, VA is developing quality measurement tools to be used for both fee basis and contracted care. Because community capabilities differ widely, and the needs for fee basis or contracted care similarly vary by locale, our approach has to be tailored to meet specific local constraints. Project HERO, which represents one of VA's first efforts at managing and consolidating contracted care, has allowed us to develop and test combinations of metrics, such as facility accreditation, provider credentialing, access measures, patient safety incident evaluation, clinical documentation submission, and patient satisfaction. In addition, the parent VA medical center provides local quality management and peer review of selected clinical records, to ensure outside care meets our own standards. We note that several of the Models for Care Coordination outlined by Bodenheimer (reference 1), such as electronic referral and data capture, referral agreements, and investing in care coordination, are currently in the process of testing and adoption. Wider use of electronic health records by community practices, and greater diffusion of personal health record usage (My Health*e*Vet) among Veterans will further support the sharing of clinical information that will support both quality monitoring and continuity of care.

ORGANIZATIONAL PLACEMENT OF OFFICE OF RURAL HEALTH

Question 2. The Independent Budget has raised concerns with the placement of the VA's Office of Rural Health within the organization. Specifically, they are concerned that by placing ORH in the VHA Office of Policy and Planning—rather than closer to the operational arm of the VA system—could, "frustrate, delay or even cancel initiatives established by the Rural Health staff." Would you respond to these concerns?

Response. Placing the Office of Rural Health (ORH) in the Office of the Assistant Deputy Under Secretary for Health for Policy and Planning was a purposeful decision made by the Under Secretary for Health after carefully evaluating what office was best equipped with technical resources and leadership skills to assure the successful creation and operation of this critical new office. The Veterans Health Administrations' (VHA) Office of Policy and Planning has well-established relationships with program offices engaged in developing services that meet the health care needs of Veterans in rural communities; it also works closely with the Office of the Deputy Under Secretary for Health for Operations and Management and Veterans Integrated Service Networks (VISN) leadership.

VHA's Office of Policy and Planning is responsible for several functions directly connected with access and care issues for Veterans in rural areas. For example, the Office is intimately involved with the annual strategic planning process, which works with local facilities and VISN to identify and address the need for community-based outpatient clinics (CBOC) in market areas across the country. ORH's presence provides a voice for the needs of rural Veterans during this process.

VHA's Office of Policy and Planning is also responsible for forecasting projections and conducting geospatial analyses to identify communities of underserved Veterans. These are instrumental in helping ORH achieve its goals of addressing gaps in services, reducing drive times for Veterans and ensuring resources are provided to high-need areas.

Moreover, ORH works closely with VHA's Operations and Management to ensure the interests of rural Veterans are represented. VA recognizes that every local community is different, with unique challenges and opportunities. By working with Operations and Management, ORH supports local solutions. For example, in December 2008, VA provided almost $22 million directly to VISNs to help them immediately

[1] Bodenheimer, T. "Coordinating Care: A Perilous Journey through the Health Care System." New England Journal of Medicine. 2008; 10; 358: 1064–1071.

[2] Gans, D et al. "Medical Groups' Adoption of Electronic Health Records and Information Systems." Health Affairs. 2006; 24;5: 1323–1333.

implement programs to improve services for rural Veterans. This funding is part of a 2-year program focusing on initiatives such as new technologies, provider recruitment and retention, and close cooperation with other organizations at the Federal, State and local levels. Facilities and networks are using these funds to sustain current programs, initiate pilot programs and establish new outpatient clinics.

By positioning ORH under VHA's Office of Policy and Planning, ORH can easily reach out not only to VISNs but to program offices within VHA. Most recently, in February 2009, ORH distributed guidance to VISNs and program offices regarding the allocation of the remaining funds to enhance rural health care programs. Program offices and VISNs are eligible to apply for this funding, which will support programs in six key areas of focus: access, quality, technology, workforce, education and training and collaboration strategies. Projects may include leveraging existing, proven initiatives, such as structured initiatives to expand fee-basis care; developing collaborations with Federal and non-Federal partners; accelerating telemedicine deployment; funding innovative pilot programs; and increasing access points in rural and highly rural areas (e.g., outreach clinics in areas not meeting VA's drive time standards, or developing mobile clinics). ORH continues to ensure program offices and VHA's Operations and Management are involved in all programmatic activities, and ORH's placement under the VHA Office of Policy and Planning provides the appropriate vehicle for these collaborations.

FUNDING FOR ORH

Question 3. Ms. Hawthorne, the Office of Rural Health was established only a few years ago and it was assigned the rather broad role of overseeing the health care services provided to millions of rural Veterans across the country. I want to make sure that your office has the resources it needs to ensure it performs its role as effectively as possible. In your opinion, does the Office of Rural Health have the resources it requires to achieve its full potential?

Response. ORH is sufficiently funded to meet the needs of rural Veterans. Our funding in fiscal year (FY) 2009 is supporting important initiatives, such as the rural health resource centers, mobile clinics, outreach clinics, VISN rural consultants, mental health and long-term care projects. We have also been able to support new initiatives through direct funding to VISNs and by soliciting requests from program offices and facilities to support programs in six key areas of focus, including access, quality, technology, workforce, education and training, and collaboration strategies. Successful programs will be included in the base budget of ORH, the facility or network, or the program office in the future.

MENTAL HEALTH STIGMA

Question 4(a). The wars in Iraq and Afghanistan present a twofold challenge when it comes to caring for our rural Veterans. As you know, nearly half of servicemembers deployed in Iraq and Afghanistan are from rural areas. On top of this, study after study has shown high rates of TBI and PTSD among returning servicemembers. Folded together, these facts present a real challenge for the Office of Rural Health and VA generally. I think all of us here recognize that VA will have to be smart about how it approaches rural health care for Iraq and Afghanistan Veterans. Have you found any evidence that the stigma of seeking mental health care is greater in rural areas than in more urbanized sections of the country?

Response. VA is not aware of any research that directly addresses the question of whether there is a greater degree or prevalence of stigmatization of mental health care in rural areas compared to more urban locations.

Question 4(b). If you have identified this as a problem, what steps is VA taking to decrease the stigma in rural areas?

Response. VA is reducing the stigma of seeking mental health care in both urban and rural settings through several initiatives. First, VA has integrated mental health care into primary care settings. VA screens any patient seen in our facilities for depression, Post Traumatic Stress Disorder (PTSD), problem drinking and military sexual trauma. We have incorporated this screening and treatment into primary care settings. We further offer programs for Veterans at risk of suicide, Veterans who are homeless, and Veterans who have experienced military sexual trauma. We provide these services by conducting an initial evaluation of all patients with potential mental health issues within 24 hours of contact, and we provide urgent care immediately. We are close to meeting our new standard of care—to see all new patients seeking a mental health care appointment within 14 days of their requested date 95 percent of the time; the standard is 95 percent rather than 100 percent to allow for the occasional Veteran who may prefer to delay this evaluation,

perhaps because of planned travel. Nationally, we see 95.3 percent of patients within the 14-day standard.

VA provides mental health care in several different environments, including Vet Centers. There are strong, mutual interactions between Vet Centers and our clinical programs. Vet Centers provide a wide range of services that help Veterans cope with and transcend readjustment issues related to their military experiences in war. Services include readjustment counseling for Veterans, marital and family counseling necessary for the successful readjustment of the Veterans, bereavement counseling, military sexual trauma counseling and referral, demobilization outreach/services, substance abuse assessment and referral, employment assistance, referral to VA medical centers, Veterans Benefit Administration (VBA) referral, and Veterans community outreach and education. Vet Centers provide a non-traditional therapeutic environment where Veterans and their families can receive counseling for readjustment needs and learn more about VA's services and benefits. By the end of FY 2009, VA will offer 271 Vet Centers with 1,526 employees to address the mental health and readjustment needs of Veterans. Additionally, VA is deploying a fleet of 50 new Mobile Vet Centers early this year; they will provide outreach to returning Veterans at demobilization activities across the country and remote areas.

Care Coordination/General Telehealth (CCGT) programs support the delivery of specialist care in the patient's local community in urban, rural and highly rural settings. CCGT programs encompass 36 clinical specialties but currently focus on mental health and rehabilitation needs. In FY 2008, over 48,000 Veterans received care nationally through CCGT of which 29,000 Veterans received mental health care via tele-mental health. CCGT services are provided at 149 VA medical centers and 353 community based outpatient clinics. In FY 2008 Veterans received this care at 171 sites which were in rural or highly rural areas.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO KARA HAWTHORNE, DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION AND TO ADAM W. DARKINS, MD, CHIEF CONSULTANT FOR CARE COORDINATION, VETERANS HEALTH ADMINISTRATION

PARTNERING WITH FQHCS AND CMHC FOR TELE-MENTAL HEALTH

Question 1. Can you tell me what VA is doing in the area of tele-mental health counseling and what you think about the idea of using federally Qualified Health Centers and Community Mental Health Centers as satellite locations where VA patients can link up over the internet with VA doctors who can provide them with mental health counseling from a community-based outpatient clinic (CBOC) or VA medical center? Is this a way we can expand the reach of VA's care into rural areas?

Response. All services provided in VA's routine delivery of care via tele-mental health can be considered to include "counseling." In FY 2008, VA provided tele-mental health services to 29,000 Veterans. However, if a narrower definition of counseling is applied—that is, a specific session of individual or group psychotherapy, then VA conducted 2,400 individual sessions or group psychotherapy sessions with 760 Veterans via tele-mental health in FY 2008.

VA's primary obligation is to meet the health care needs of Veterans. We prefer to do this within our own facilities because we have established common standards for quality care based upon objective measures and because of the benefits of a coordinated and comprehensive electronic health record. Moreover, VA screens any patient seen in its facilities for depression, PTSD, problem drinking, and military sexual trauma. In some situations, however, the patient's needs will be better served by finding an alternate provider.

VA supports the use of federally Qualified Health Centers and Community Health Centers as satellite locations where Veterans can access care. Such access over the Internet or other telecommunications media needs to ensure privacy and confidentiality of patient data. In addition, provision of care at these sites must adhere to VA policies and procedures, provide electronic access to the requisite patient data, and satisfy patient safety considerations. Services to Veterans accessed via telehealth from federally Qualified Health Centers and Community Health Centers would provide a mechanism to expand access to care for Veterans in rural areas. Access would include technological and contracting mechanisms to ensure safe, appropriate and cost-effective clinical services. Within VA, patients are routinely offered access to face-to-face services when this is their preference.

Section 107 of Public Law 110–387 asks VA to conduct a rural pilot program in at least three VISNs to evaluate the feasibility and advisability of providing Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans (particularly

those who served as members of the National Guard or Reserve) peer services, readjustment counseling, and other mental health services. These services would be provided through a variety of arrangements with a group of community and Indian health organizations that deliver mental health services in rural areas. Tele-mental health may be one of the service delivery modalities tested in this pilot. VA's Office of Mental Health Services is currently in the process of implementing the pilot in collaboration with the Office of Rural Health.

PARTNERING WITH THE NATIONAL HEALTH SERVICE CORPS

Question 2. It is my understanding that VA is not currently partnering with the National Health Service Corps to help increase the number of high quality medical professionals in rural areas. Is that correct? Can you tell the Committee whether you think there would be some benefit in such a partnership? We obviously don't want to take Health Service corps doctors away from the communities they serve, but could there be some kind of connection with VA?

Response. VA does not currently have an active partnership with the National Health Services Corps (NHSC) in the development of medical professionals. Due to certain legal restrictions, VHA facilities do not meet Department of Health and Human Services (HHS) criteria to be designated as NHSC practice sites for fulfillment of service commitments. To be eligible under HHS' criteria to participate, VA would have to accept Medicare, Medicaid and indigent patients.

However, to develop health care professionals, VHA modeled the Health Professionals Educational Assistance Program, Employee Incentive Scholarship Program (EISP) after the programs sponsored by HHS' National Health Services Corps. Since 2000, VA has offered scholarship programs for VHA employees that assist in meeting staffing needs through academic degree training for health care occupations. Over 4,500 individuals have graduated from academic degree programs under EISP. Many employees returned to school to enhance their existing professional credentials, but approximately 500 of these graduates were newly licensed health care providers. The statute requires a VHA service obligation modeled after the NHSC program, but fulfillment of the service agreement is not limited to rural areas. The statute does provide the Secretary the flexibility to require that service obligations be performed in any VHA facility as needs dictate. To date the program has not implemented this relocation provision or specifically used scholarships as a mechanism to geographically distribute the workforce to rural areas. Many VA employees in rural areas have participated in EISP.

From the late 1980s through 1998, VA had statutory authority for a scholarship program for individuals who were not VA employees; however authority for that program expired December 31, 1998 and has not been reauthorized. This provision would be most similar to the NHSC program in terms of providing scholarships to individuals in exchange for service in hard-to-recruit locations. Chairman Akaka has introduced legislation to extend the sunset provision in the current statute.

CARE FOR FAMILIES LIVING IN RURAL AREAS

Question 3. We have spent a good deal of time at the hearing discussing the care for our Veterans and that is, of course, the top priority. But we also have to recognize that when a Veteran needs help, as many of our Veterans from Iraq and Afghanistan and other conflicts do, that also means the family needs assistance. What is VA doing to help connect to family members of rural Veterans, especially those from Iraq and Afghanistan, to let them know about counseling services, expanded through congressional action in the 110th Congress (Public Law 110–387), available for family members through VA?

Response. VA appreciates that families are central to the readjustment process for combat Veterans. In response to the growing numbers of Veterans returning from combat in OEF/OIF, the Vet Centers initiated an aggressive outreach campaign to welcome home and educate returning servicemembers at military demobilization and National Guard and Reserve sites. Through its community outreach and referral activities, the Vet Center program also provides many Veterans and family members the means of access to other VHA and VBA programs. To augment this effort, the Vet Center program recruited and hired 100 OEF/OIF Veterans to provide the bulk of this outreach to their fellow Veterans and Veterans' family members. The program's focus on aggressive outreach activities has resulted in the provision of timely Vet Center, and other VA, services to significant numbers of OEF/OIF Veterans and family members. Vet Centers also provide readjustment counseling services for Veterans, including marital and family counseling as necessary for the successful readjustment of the Veteran.

In another area, VA actively supports OEF/OIF transition through the Department of Defense (DOD) Yellow Ribbon Reintegration Program (YRRP). The National Defense Authorization Act for FY 2008 (Section 582) tasked the Secretary of Defense with establishing a national combat Veteran reintegration program to provide support and outreach to National Guard and Reserve members throughout the entire deployment cycle. VA plays a key role in the DOD YRRP office, which opened in March 2008, by providing a full-time VA Liaison to the office. The VA Liaison works closely with the program management and service liaison officers within the program office and provides technical expertise and guidance pertaining to VA benefits, services, and programs available to National Guard and Reserves and their family members. The YRRP is currently active in 54 States and territories, and engages servicemembers and their families in the pre-, during and post-deployment stages, including 30, 60, and 90 days after deployment. At the local level, VA supported 185 Guard and Reserve Yellow Ribbon Events in FY 2008 through the end of March 2009. A total of 25,993 servicemembers attended these events, and 17,809 family members did, too. VA provides information, assistance, and referrals to servicemembers and helps them enroll in VA care.

Preventing Veteran suicide is a paramount goal for VA. As part of VA's Suicide Prevention Initiative, two public service announcements (PSA) have been developed to speak to Veterans and their families. The first PSA released features actor Gary Sinise and targeted Veterans directly. The second PSA features TV personality Deborah Norville and includes key messages designed to help families and loved ones of Veterans recognize warning signs of suicide. The PSAs also provide helpful information to aid in support and intervention.

In addition, VA is developing healthy cooking videos as part of the HealthierUS Veterans initiative for Veterans and their families. These videos aim to promote a healthier life style by eating right and staying active. The cooking videos will help Veterans and their families make healthier choices in purchasing and preparing food to achieve a healthier diet.

EFFORTS TO INCREASE PAY FOR VA EMPLOYEES

Question 4. I mentioned in my opening statement the challenges we are having recruiting and retaining VA employees in Vermont because of the low locality pay level in our areas compared to neighboring states. Is this a complaint you have heard in other parts of the country? What suggestions do you have to fix this problem? Does VA have any involvement in the Office of Personnel Management's locality pay decisions?

Response. VA recognizes there are pay disparities in some areas, specific to local occupations, and we are working aggressively to address these disparities within our current resources. VHA has the authority to adjust salary rates for hybrid title 38 and title 38 occupations to remain competitive if there are difficulties recruiting or retaining employees in a given area. We continue to offer incentives, salary adjustments, scholarships and loan repayment assistance. VHA recently awarded a contract to a private consultant to gather current salary data specific to local labor markets to facilitate a comparison across all medical facilities, including rural areas. This analysis will assist VHA in adjusting salaries as needed. VHA does not specifically have input into locality pay decisions by the Office of Personnel Management, but we have the authority to adjust salaries for title 38 and hybrid title 38 positions.

PEER-TO-PEER OUTREACH

Question 5. What does the Office of Rural Health think about using more peer-to-peer outreach to help connect to our rural Veterans and their families to make sure they know about and can access VA services available to them? In Vermont, we have a program operated by the Vermont National Guard with assistance from VA called the "Vermont Veterans and Family Outreach Program." This program uses VA-trained Veterans to conduct outreach to returning servicemembers and we have found it is quite an effective way to contact Veterans, who may normally be hesitant to seek out help, and connect them to needed services. Could Vermont's program be eligible for inclusion in the pilot program required by Section 107 of Public-Law 110–387?

Response. VA recognizes the importance of the Veteran-to-Veteran connections, and VA is proud that it is one of the leading agencies in the Federal Government in terms of employing Veterans. There is no better example of this commitment than in VA's Vet Center program. By design, the Vet Center program promotes the value of Veteran-to-Veteran peer readjustment services, a time-honored lesson throughout the program's 30-year history. The Vet Center experience teaches that combat Veterans strongly prefer to talk to other Veterans who understand the mili-

tary culture and who share similar combat experiences. Receiving outreach and readjustment counseling from a fellow warrior of the same age group and military experience establishes an immediate connection and facilitates trust between Veterans. This opens the door to care for many combat Veterans who would not otherwise be receptive to entering the health care system. The Readjustment Counseling Service initiated the Vet Center Global War on Terror (GWOT) Veteran outreach program in the wake of hostilities in Afghanistan and Iraq. VA has added 100 GWOT Veterans to the Vet Center staff across the country. These newest members of the Vet Center staff are primarily involved in our outreach efforts to make contact with their fellow Veterans as soon as they return from combat. Their unique ability to understand and connect with each other allows these staff members to help servicemembers access VA services as soon as possible after returning. Vet Center GWOT outreach specialists conduct proactive outreach services for all returning warriors and their families at Active Military, National Guard, and Reserve sites, and at other community locations. Since 2004, the Vet Center Program has hired over 200 additional OEF/OIF combat Veterans into other staff positions at Vet Centers.

Section 107 of Public Law 110–387 asks VA to conduct a rural pilot program in at least three VISNs to evaluate the feasibility and advisability of providing OEF/OIF Veterans (particularly those who served as members of the National Guard or Reserve) peer services, readjustment counseling, and other mental health services. These services would be provided through a variety of arrangements with a group of community and Indian health organizations that deliver mental health services in rural areas. tele-mental health may be one of the service delivery modalities tested in this pilot. VA's Office of Mental Health Services is currently in the process of implementing the pilot in collaboration with the Office of Rural Health.

Chairman AKAKA. Now let me call on and welcome our second panel of witnesses to today's hearing.

We will hear first from Reverend Ricardo Flippin, a community leader on the front lines in West Virginia, describing the health problems of our veterans who live in rural areas.

Then we have Alan Watson, who is Chief Executive Officer of two rural hospitals. He will describe some of the challenges in providing hospital care for veterans in communities where there are no VA hospitals.

Next we will have Tom Loftus, Commander of an American Legion Post. Commander Loftus will tell the Committee about the problems that our veterans face when they are trying to obtain outpatient care in communities without a VA clinic.

Finally, Matt Kuntz, Executive Director of the Montana Chapter of the National Alliance on Mental Illness, will share information on the particular problems faced by veterans with mental illness who need to obtain care in a rural community.

Thank you all for joining us today. Your full statements will appear in the record.

Reverend Flippin, will you please begin?

STATEMENT OF REVEREND RICARDO C. FLIPPIN, PROJECT COORDINATOR, WEST VIRGINIA COUNCIL OF CHURCHES, CARE-NET: CARING BEYOND THE YELLOW RIBBON

Rev. FLIPPIN. Chairman Akaka, Ranking Member Burr in absentia, and Members of the Senate Committee on Veterans' Affairs, thank you for the honor and the opportunity to speak to you today about the health care needs of our rural veterans.

My name is Reverend Ricardo Flippin from Charleston, West Virginia. I represent CARE-NET: Caring Beyond the Yellow Ribbon, a project of the West Virginia Council of Churches funded by the Claude Worthington Foundation and the Attorney General Office of the State of West Virginia.

The State of West Virginia supports a military complex of Army and Air National Guard, Army and Air Reserve Components, plus Navy and Marine Reserve Units. Many of our soldiers in these units are serving their second or third tour of duty in Iraq or Afghanistan.

Unlike the regular active army member who returns to a permanent base with medical clinics, surrounded by other soldiers and soldier families for support, our military members—National Guard—return home to a civilian community where few understand their military experiences. West Virginia armories are scattered across the State, many hours' drive from military or veteran health care facilities.

CARE-NET: Caring Beyond the Yellow Ribbon works to connect communities and helping professionals in the community to our returning veterans. This is particularly important in the areas without VA facilities. CARE-NET identifies the needs of the veteran and his or her family—needs like: the tools to fight addiction; Post Traumatic Stress Disorder; Traumatic Brain Injury; and equipping their families with the skills to cope with these invisible wounds. And then we try to match those needs with the resources in our small communities.

This is particularly important to our rural veterans. In West Virginia, more than half of our veterans live in rural areas. And we know that veterans living in those areas are more likely to suffer from PTSD or depression than our veterans in urban areas. Our researchers think the reason for this is a lack of mental health care providers in rural areas. The VA itself has done work showing that rural veterans have more serious and costly health care problems than urban veterans.

Many believe that TRICARE, the military insurance that provides veterans with 6 months of coverage after discharge, solves this problem. However, many providers in rural communities will not take TRICARE because it does not reimburse at the community rate. Then when TRICARE runs out, our veterans must rely on the VA. Many of our community providers will not accept VA payments either. In West Virginia, this can mean that our veterans must travel for hours to get care at VA facilities.

Organizations like CARE-NET across the country are trying to connect our community resources with our returning veterans in those areas without VA hospitals or clinics. We urge the Committee and the VA to work with community health care providers and organizations like CARE-NET to use all our resources in rural communities to care for our veterans. We must reach out to our wounded veterans wherever they live and guarantee that they can get the care they need—a promise should be a promise, no matter where the servicemember calls home.

Thank you for this opportunity to speak on behalf of our rural veterans and their communities.

[The prepared statement of Rev. Flippin follows:]

PREPARED STATEMENT OF REVEREND RICARDO C. FLIPPIN, COORDINATOR, CARE-NET: CARING BEYOND THE YELLOW RIBBON, WEST VIRGINIA COUNCIL OF CHURCHES

Chairman Akaka, Ranking Member Burr, and Members of the Senate Committee on Veterans' Affairs: thank you for the honor and the opportunity to speak to you today about the health care needs of our rural veterans.

My name is Reverend Ricardo Flippin from Charleston, West Virginia. I represent CARE-NET: Caring Beyond the Yellow Ribbon, a project of the West Virginia Council of Churches funded by the Claude Worthington Foundation and the Attorney General Office of the State of West Virginia.

The state of West Virginia supports a military complex of Army and Air National Guard, Army and Air Reserve Components, plus Navy and Marine Reserve Units. Many of our soldiers in these units are serving their second or third tour of duty in Iraq or Afghanistan.

Unlike the regular military member (active duty) who returns to permanent bases with medical clinics, surrounded by other soldiers and soldier families for support, our military members return home to a civilian community where few understand their military experiences. West Virginia armories are scattered across the state, many hours' drive from military or veteran healthcare facilities.

CARE-NET: Caring Beyond the Yellow Ribbon works to connect communities and helping professionals in the community to our returning veterans. This is particularly important in the areas without VA facilities. CARE-NET identifies the needs of the veteran and his or her family—needs like the tools to fight addiction, PTSD and TBI, and equipping their families with the skills to cope with these invisible wounds. And then we try to match those needs with the resources in our small communities.

This is particularly important to our rural veterans. In West Virginia, more than half of all our veterans live in rural areas. And we know that veterans living in those areas are more likely to suffer from PTSD or depression than our veterans in urban areas. Our researchers think the reason for this is a lack of mental health care providers in rural areas. The VA itself has done work showing that rural veterans have more serious and costly health care problems than urban veterans.

Many believe that TRICARE, the military insurance that provides veterans with six months of coverage after discharge, solves this problem. However, many providers in rural communities will not take TRICARE because it does not reimburse at the community rate. Then, when TRICARE runs out, our veterans must rely on the VA. Many of our community providers will not accept VA payments either. In West Virginia, this can mean that our veterans must travel for hours to get health care at VA facilities.

Organizations like CARE-NET across the country are trying to connect our community resources with our returning veterans in those areas without VA hospitals or clinics. We urge the Committee and the VA to work with community health care providers and organizations like CARE-NET to use all our resources in rural communities to care for our veterans. We must reach out to our wounded veterans wherever they live and guarantee that they can get the care they need- a promise should be a promise, no matter where the servicemember calls home.

Thank you for this opportunity to speak on behalf of our rural veterans and their communities.

Chairman AKAKA. Thank you very much, Rev. Flippin.

Now we will hear from Mr. Watson.

STATEMENT OF ALAN WATSON, CHIEF EXECUTIVE OFFICER, ST. MARY'S MEDICAL CENTER OF CAMPBELL COUNTY, LAFOLLETTE, TENNESSEE

Mr. WATSON. Thank you, Chairman Akaka, Ranking Member Burr in absentia, distinguished Members of this Committee. Thank you for the opportunity to speak to you today about the challenges small communities encounter when providing health care to our veterans.

I am Alan Watson, Chief Executive Officer of St. Mary's Medical Center of Campbell County in LaFollette, Tennessee. St. Mary's Medical Center of Campbell County is located in a rural Appalachian community and provides 56 acute-care beds, 10 senior behavioral health beds, and 98 long-term-care beds. We offer a broad array of acute-care services including emergency care, general surgery, pulmonary medicine, cardiology, senior behavioral health, and imaging services.

In our county, almost one-fourth of the population is below the Federal poverty level. All of our health care providers provide care each day without the guarantee of reimbursement for that care, making it difficult for physicians to be recruited into this area. The National Health Service Corps has been a valued resource in recruiting providers; however, we still need more providers in the community.

Many of the patients that we serve on a daily basis are veterans. Thirty-five hundred veterans live in the county where our hospital is located. I would first like to say that I believe the care that veterans receive in VA facilities is excellent if they are fortunate enough to have the means to travel to those facilities or live near them. Our concerns with the VA system are not with the care it delivers to veterans within the system, but with the access to that care and continuity of care for our rural veterans.

Access to care for our veterans is limited by the distance to VA facilities and the number of providers available at those facilities. The closest outpatient clinic to LaFollette, Tennessee, is located 1 hour away in Knoxville. This clinic provides primary care, pharmacy, and limited diagnostic services. Specialist care is not available to manage the many disease processes identified in our veteran population. Veterans who require hospitalization and/or specialist care must drive to the Veterans Administration Medical Center in Mountain Home, Tennessee, a 2½-hour drive. The next closest VA Medical Center is located in Murfreesboro, Tennessee, 3½ hours by car.

These distances present significant challenges to our veterans considering that many cannot drive and do not have family members available to drive them to either Mountain Home or Murfreesboro. In addition, it is reported that local ambulance services are reluctant to transport patients because payment by the VA has been denied in the past.

The second limiting factor related to care access is the low numbers of providers at the various VA clinics. Appointments are scheduled weeks and sometimes months in advance. Acute patients can "walk in." However, there is no guarantee that they will be seen that day. In many cases, the patients will be forced to seek care in our emergency department while waiting for appointments in VA clinics.

The continuity of care that is provided to our veterans is the second area of concern for our community. Problems occur related to communication between providers, long-term-care placement, and the options for homeless veterans.

First, follow-up communication between VA providers and local primary care physicians is non-existent. In addition, it is difficult to obtain records from the VA clinics regarding ancillary testing and current medication lists.

Second, it is challenging for hospitals to place patients needing long-term care. Many local long-term-care facilities are reluctant to accept VA patients due to poor reimbursement and the volumes of paperwork required. This results in longer lengths of hospitalization while placement options are being explored. It has been well documented that longer-than-expected hospitalization stays are

considered to be a patient safety issue due to the potential for exposure to hospital-acquired infections.

Third, there are no resources for homeless veterans who do not qualify for placement in long-term care but are too sick to return to the street.

I leave you with a patient care story that we have experienced in our own community.

A 50-year-old veteran entered our hospital with liver failure. He needed residential hospice care because his elderly mother could not care for him during his last days. The only options provided by the VA were transfer to the Mountain Home facility 2½ hours away or admission to a local nursing home. All of our local nursing homes were either full or initially refused the patient due to payment concerns. The patient's elderly mother sat at his bedside in tears due to fear that her son would be moved to Mountain Home and she would not be with him during his death. After 13 days of hospitalization, a local nursing home finally agreed to take the patient.

Thank you for your time and concern for our veterans in rural communities.

[The prepared statement of Mr. Watson follows:]

PREPARED STATEMENT OF ALAN WATSON, CHIEF EXECUTIVE OFFICER, SAINT MARY'S MEDICAL CENTER OF CAMPBELL COUNTY, LAFOLLETTE, TENNESSEE

Chairman Akaka, Ranking Member Burr, and Distinguished Members of this Committee, and all others attending, thank you for the opportunity to speak to you today about the challenges small communities encounter when providing health care to our veterans.

I am Alan Watson, Chief Executive Officer of St. Mary's Medical Center of Campbell County in LaFollette, Tennessee. St. Mary's Medical Center of Campbell County is located in a rural Appalachian community and provides 56 acute care beds, 10 senior behavioral health beds, and 98 long term care beds. We offer a broad array of acute care services including Emergency Care, General Surgery, Pulmonary Medicine, Cardiology, Senior Behavioral Health and Imaging Services.

In our county, almost one-fourth of the population is below the Federal poverty level. All of our healthcare providers provide care every day without the guarantee of adequate reimbursement for that care, making it hard to recruit physicians in this area. The National Health Service Corps has been a valued resource in recruiting providers to our areas, but we still need more health care providers in our community.

Many of the patients we serve are veterans. 3,500 live in the county where our hospital is located. And I believe that they get wonderful health care from VA facilities if they are fortunate enough to have the means to travel to them, or live near them. Our concerns with the VA system are not with the care it delivers to veterans within the system, but with access to that care and continuity of care for our rural veterans.

ACCESS TO CARE

Access to care for our veterans is limited by the distance to VA facilities and the number of providers available at those facilities. The closest outpatient clinic is located 1 hour from LaFollette in Knoxville, Tennessee. This clinic provides primary care, pharmacy, and limited diagnostic services. Specialist care is not available to manage the many disease processes identified in our veteran population. Veterans who require hospitalization and/or specialist care must drive to the Veterans Administration Medical Center in Mountain Home, TN, a 2.5 hour drive. The next closest VA Medical Center is located in Murfreesboro, TN, a 3.5 hour drive.

These distances present significant challenges to our veterans considering that many cannot drive and do not have family members available to drive them to Mountain Home or Murfreesboro. In addition, it is reported that local ambulance services are reluctant to transport patients because payment has been denied in the past by the VA.

The second limiting factor related to care access is the low numbers of providers at the various VA clinics. Appointments are scheduled weeks and sometimes months in advance. Acute patients can "walk in". However, there is no guarantee that they will be seen that day. In many cases, the patients will be forced to seek care in our emergency department while waiting for appointments in VA clinics.

CONTINUITY OF CARE

The continuity of care provided to our veterans is the second area of concern for our community. Problems occur related to communication between providers, Long Term Care placement, and the options for homeless veterans.

First, follow up communication between VA providers and local primary care physicians is minimal or non-existent. In addition, it is difficult to obtain records from the VA clinics regarding ancillary testing and current medication lists.

Second, it is challenging for hospitals to place patients needing Long Term Care. Local Long Term Care facilities are reluctant to accept VA patients due to poor reimbursement and the volumes of paper work required. This results in longer lengths of hospitalization while placement options are being explored. It has been well documented that longer than expected hospitalization stays are considered to be a patient safety issue due to the potential for exposure to hospital acquired infections.

Third, there are no resources for homeless veterans who do not qualify for placement in Long Term Care but are too sick to return to the street. In many cases, these patients remain in the hospital for long periods of time until their disease process can be managed in their homeless situation. Again, we have created a patient safety issue due to the longer than expected length of stay.

I leave you with two patient care stories that we have experienced in our community:

A 50-year-old veteran entered our hospital with liver failure. He needed residential hospice care because his elderly mother could not care for him during his last days. The only options provided by the VA were transfer to the Mountain Home facility 2.5 hours away or admission to a local nursing home. All of our local nursing homes were either full or initially refused the patient due to payment concerns. The patient's elderly mother sat at his bedside in tears due to fear that her son would be moved to Mountain Home and she would not be with him during his death. After 13 days of hospitalization, a local nursing home finally agreed to take the patient.

An 84-year-old veteran was admitted to our facility after being seen at a VA Medical Center 3 days earlier for a large ulcer on his one leg. He was a blind amputee, with many other medical problems. The patient was informed by the VA that his condition did not warrant hospital admission. Adult protective services listed his living conditions as extremely poor. His wife was already in a nursing home and they had no children or other local family members to care for him. Our case managers worked with the VA system for 6 days before approval was granted for nursing home placement in another community. Our staff spent hours completing forms and placing phone calls to obtain this approval. After his placement, payment to the hospital for our care was denied by the VA for his entire length of stay because it was not deemed a medical emergency and VA facilities were "feasibly available" to provide his care.

Thank you for your time and concern for our veterans in rural communities.

Chairman AKAKA. Thank you very much, Mr. Watson.
Mr. Loftus?

STATEMENT OF THOMAS LOFTUS, COMMANDER, THE AMERICAN LEGION, POST 45, CLARKSVILLE, VIRGINIA

Mr. LOFTUS. Chairman Akaka, Senator Burr in absentia, and distinguished Members of the Committee, thank you for the opportunity to speak today about veterans living in rural areas.

My name is Tom Loftus. I work every day with veterans living in rural areas, trying to help them find health care. I am myself a veteran, a disabled veteran, having served in the Air Force Medical Service Corps during the Vietnam era and in the Public Health Service Corps as a commissioned officer, in the National Health Service Corps, and at the community health clinics. Having left the Air Force, I was also the Chief Operating Officer of the National

Health Service Corps, Region III. I was Chief Executive Officer of the Public Health Service's Occupational Health Division, and Administrator of the Occupational Medicine Department at State. More recently, I have worked with a variety of community health centers on physician recruitment, physician retention, and staffing.

What brings me here today is the situation in the community where I live—a small town in southern Virginia called Clarksville, population 1,200. The county has a population of 30,000. Prior to opening up this new command position at the American Legion, I was running a community health service clinic in Boydton, Virginia, population 400. So, I am very familiar with the issues of both where you are located and health care delivery.

Many of the issues that I have about the veterans you have already heard. Many revolve around access to health care. Our particular catchment area is in VISN 6 out of Durham. We are approximately an hour and one-half to Richmond; we are an hour and one-half to Durham.

The big problem is neurological problems. We are 4 hours to VA Medical Center Salem, 3 hours to VA Medical Center Hampton. Many of our patients who have PTSD have to go to group therapy either at Durham or in Richmond, or if they have profound psychotic diagnoses, which a lot of them do, they have to go Hampton or Salem.

As a minimum, there should be community-based personnel who can assess Post Traumatic Stress Disorder and Traumatic Brain Injury, with the understanding that our veterans can get follow-up at VA Medical Center Hampton and VA Medical Center Salem if needed. The problem is access. Our particular part of the country has no intra-city bus service, no intra-city train service, and/or taxi service. The transportation situation does not offer an easy way for veterans and family members to travel.

The second issue we have is we are part of a national network, Department of Health and Human Services' Community Health Centers—and I was very impressed with Senator Burr's comment that there is discussion going on between the Department of Health and Human Services, the Health Resources Service Administration, Bureau of Primary Care, and the Indian Health Service to address the access issue that was spoken about earlier.

People forget that we have 10,000 federally qualified community health clinics in the United States. In my area alone, covering six counties, we have seven of them—all fully equipped, very modern, well equipped. I regret to say that one clinic in Boydton, Virginia, is losing its board-certified psychiatrist next month, and its trauma-trained counselor because they cannot make a living on Medicaid reimbursement—Southern Dominion Health System with its multiple clinics in Southside Virginia.

Another issue is women's health. A significant fraction of the staffing of the community health clinics are women. A significant fraction of students in medical school are women. A third of the graduates of medical school are women. So as a result, a significant fraction of women practitioners are in these community health services, and they should be utilized for veteran women health problems. Women have just as many problems as the men—PTSD/TBI, family separation, relationship problems, et cetera.

One problem with the VA is voucher services. The only people that are allowed to get a voucher from the VA now is a 100-percent disabled vet. It is only good for $150 to $200.

I will summarize by saying this: The simplest solution from the community health service is to put in a veteran medical center terminal—VA could put terminals into clinics. Most of these clinics have electronic medical records. I want to also compliment VA-Richmond and VA-Durham. They do a superb job in medical care.

Thank you, Chairman.

[The prepared statement of Mr. Loftus follows:]

PREPARED STATEMENT OF THOMAS LOFTUS, COMMANDER, AMERICAN LEGION POST #45

Chairman Akaka, Senator Burr, and Distinguished Members of this Committee, and all others attending, thank you for the opportunity to speak today on behalf of veterans who live in rural areas.

My name is Tom Loftus, and I work every day with veterans living in rural areas, trying to obtain health care for them. I am myself a veteran, having served in the Air Force Medical Service Corps during Vietnam and in the Public Health Service. Since leaving the Air Force, I have also been the Chief Operating Officer of the National Health Service Corps, Chief Executive Officer of the Public Health Service's Occupational Health Division, and Administrator of the Department of State's Occupational Medicine program. More recently, I have worked with community health centers on provider recruitment and health care management services.

What brings me here today is the situation in the community where I live, a small town in Southern Virginia, called Clarksville. As Commander of American Legion Post #45, I hear the concerns of our veterans daily. Many revolve around their access to health care. Veterans in my community must travel 3–4 hours to Salem or Hampton, Virginia for neurological care. A 3–4 hour trip can be overwhelming for some of our veterans with Traumatic Brain Injury.

At a minimum, there should be community based personnel who can assess veterans for Post Traumatic Stress Disorder and Traumatic Brain Injury, with the understanding that our veterans can follow-up at the Hampton and Salem hospitals if needed. Even for our veterans needing routine care for conditions like diabetes and high blood pressure, or group therapy for mental health conditions, they must travel 1–2 hours to Durham, North Carolina, or Richmond, Virginia for these services.

There are some who believe that the problems of rural veterans have been solved by reimbursing community providers under a fee-for-service system. Under this system, the VA gives the veteran a voucher that they can use to get a specific screening or test in the community. The voucher amounts vary but in our area are usually in the $150-$200 range. These are episodic payments for one time use. They are available only sporadically and not used for routine medical care.

This creates a situation where veterans receive occasional care in the community, which is often poorly coordinated with the care they do receive in VA facilities because local providers do not have access to VA's electronic medical record. While we understand that the VA could never construct a VA hospital or clinic in every community like ours in the country, we believe there are opportunities for the VA to work with community health centers to provide care where VA facilities do not exist. For example, there are over 20 Bureau of Primary Care centers funded by the Department of Health and Human Services in Southern Virginia alone.

To solve this problem the VA could credential and privilege VA providers to work in our community health centers, allowing them to service our veterans without the expense of building separate VA facilities. As VA employees, they would have access to the electronic medical record, and be able to put health information gathered in the community directly into the VA's electronic medical record, ensuring that any provider seeing the veteran would have access to all of his or her health information. If it is not feasible for the VA to hire these providers, then they might expand their fee basis voucher system to allow private providers and clinics to care for our veterans.

In short, every veteran, no matter where they live, deserves the best care our country can give them. The only way that this can occur is if the VA and our communities work together to solve this problem.

I thank this Committee for the opportunity to share with you the challenges our veterans in rural Southern Virginia and elsewhere face as they return to communities without VA health care facilities.

Chairman AKAKA. Thank you very much, Mr. Loftus.

Now we will hear from Mr. Kuntz.

STATEMENT OF MATTHEW KUNTZ, EXECUTIVE DIRECTOR, MONTANA CHAPTER, NATIONAL ALLIANCE ON MENTAL ILLNESS

Mr. KUNTZ. Chairman Akaka, Ranking Member Burr in absentia, and Members of the Committee, as Executive Director of the Montana Chapter of the National Alliance on Mental Illness (NAMI), I appreciate your invitation to testify before this Committee. Also on behalf of the NAMI National Office, please accept NAMI's collective thanks for this opportunity.

Mr. Chairman, my formal statement submitted to the Committee included information about NAMI and its work and important issues relevant to veterans living with mental illness under VA care. In the interest of time, I am not discussing those issues, but they are policy matters that I hope you will consider.

As a proud and grateful consumer of the VA, I thank you for your work on this Committee. I also want to thank Senator Jon Tester for identifying me to your staff as a potential witness today. Senator Tester is an incredible ally in the fight to secure adequate treatment for veterans with mental illness. After my step-brother's death, I called politicians across Montana to get help on this issue. Senator Tester was the only who called me, and I cannot thank him enough for that.

For my background, I came into this position the hard way. I lost my step-brother to a PTSD-induced suicide 15 months after he returned from Iraq. It was a tragic and utterly preventable situation. I started fighting for better care 1 week after Chris' death, and I continue to this day, eventually giving up my law practice and taking over for NAMI. I will be addressing you from that position.

Our main issue is geography. Plain and simple, Montana is the fourth biggest State in the country. We have over 147,000 square miles. That is 36 Big Islands, 3½ States of Virginia, and 2 States of Washington. It is big. And we also have a high per capita need for these services. We have a high percentage of veterans. We battle Alabama for the highest illness rate in the country, and we also have the highest percentage of wartime injuries per capita, with over 22 per 100,000. So I think it is a logical assumption that we also have just about around the highest rate of wartime PTSD per capita.

Our challenges are further complicated by our State mental health system. It is overburdened and underfunded. With all honesty, we just cannot expect that they will be able to pick up the veterans that get through the cracks.

We also have challenges in serving our Native veterans. A significant portion of our warriors come from Montana's Indian population. They have distinct and proud cultural backgrounds, and the VA must serve them in a culturally sensitive manner. While we take our enemy as we find them, we take our heroes as they find us. Our tribal veterans' representatives are a critical tool in this ef-

fort and making sure that the veteran does not become the "hot potato" between IHS and the VA.

One of the most critical issues that we have is a lack of crisis beds in our community. Plain and simple, if a veteran in Scobey, Montana, wants to commit suicide, we have no humane solution to deal with that. It is an 8-hour drive to our State mental hospital, and that is a long time for one of our heroes to be stuck in the back of a squad car.

We need to ensure that the VA has access to, or can arrange, geographically dispersed crisis beds to ensure that no veteran is made to travel more than 2 or 3 hours to a safe place of care. We are working on this at the Montana Legislature, but realistically, we cannot do it without your help. The lack of inpatient services is only making this worse.

I will come to one last conclusion. I have been working with Senator Baucus on preparing a screening measure for the Department of Defense. The real way to tackle this problem is to screen them before they hit the VA. We cannot have them dumped on our system not having any treatment for their mental illnesses, and I ask you to support us in that fight.

Thank you, Mr. Chairman. Mahalo and thank you for your kōkua.

[The prepared statement of Mr. Kuntz follows:]

PREPARED STATE OF MATTHEW KUNTZ, EXECUTIVE DIRECTOR, MONTANA CHAPTER, NATIONAL ALLIANCE ON MENTAL ILLNESS

Chairman Akaka, Ranking Member Burr, and Members of the Committee—As the Executive Director of the Montana Chapter of the National Alliance on Mental Illness (NAMI), I appreciate your invitation to provide testimony to the Committee. Also on behalf of NAMI Executive Director Michael Fitzpatrick, our NAMI Board of Directors Veterans Committee Chairman Fred Frese, Ph.D., and our national grassroots Veterans Council Chairman, Ms. Sally Miller, a neighbor of mine from Bozeman, Montana, please accept NAMI's collective thanks for this opportunity for me to testify before your Committee today.

Mr. Chairman, as a proud and grateful consumer of services provided by the Department of Veterans Affairs (VA), I thank you for your work on this Committee to sustain and improve programs for veterans. I also want to thank Senator Jon Tester for identifying me to your staff as a potential witness today. Senator Tester has been an incredible ally through all of my experiences and involvement with veterans' mental health issues. We are happy to have him represent God's Country in the Senate of the United States.

NAMI is the Nation's largest non-profit organization representing and advocating on behalf of persons living with chronic mental health challenges. Through our 1,100 chapters and affiliates in all 50 states and over 200,000 members, NAMI supports education, outreach, advocacy and biomedical research on behalf of persons with schizophrenia, bipolar disorder, major depression, severe anxiety disorders, Post Traumatic Stress Disorder (PTSD), and other chronic mental illnesses that affect children and adults.

NAMI and its veteran members established a Veterans Council in 2004 to assure close attention is being paid to mental health issues in the VA and especially within each Veterans Integrated Services Network (VISN) and at individual facilities. We advocate for an improved VA continuum of care for veterans with severe mental illness. The council includes members from each of VA's 21 VISNs. These members serve as NAMI liaisons with their VISNs; provide outreach to local and regional Veterans Service Organization units; increase Congressional awareness of the special circumstances and challenges of serious mental illness in the veteran population; and work closely with NAMI State and affiliate offices on issues affecting veterans and their families. Our members are deeply involved in consumer councils at almost 50 VA medical centers and we advocate for even more councils to be established throughout the VA system.

In respect to VA's consumer councils, some of my NAMI colleagues have learned and have asked me to report to this Committee that some VA attorneys may be using the requirements of the Federal Advisory Committee Act (FACA) as a type of shield to prevent or obstruct the establishment by VA facilities of new consumer councils in the mental health area. This is a very worrying trend. A consumer council is not a Federal advisory committee in any sense of that concept. Participating in consumer councils is at the very heart of our involvement in the care of our family members who are veterans in VA treatment programs. VA's own mental health strategic reform plan, adopted formally by the Veterans Health Administration almost four years ago, prominently calls for the establishment of mental health consumer councils as a key component of advancing recovery as a model goal for the entire VA system. NAMI hopes you will use your oversight to examine how VA attorneys could reach a conclusion that a VA mental health consumer council is a Federal advisory committee within the meaning of the FACA, particularly in the face of the hundreds of councils that have been established by VA over the years. Hopefully you can change their minds.

NAMI's Veterans Council membership includes veterans who live with serious mental illness, family members of these veterans, and other NAMI supporters with an involvement and interest in the issues that affect veterans living with mental illness. Also our Veterans Council and other NAMI resources are committed to a Memorandum of Understanding NAMI secured in 2008 with the Department of Veterans Affairs, to bring NAMI's signature education program, called "Family to Family," directly into the VA mental health treatment environment. Family to Family is a formal twelve-week NAMI educational program that enables families living with mental illness to learn how to cope with and better understand it.

NAMI's Family to Family program provides current information about schizophrenia, major depression, bipolar disorder (manic depression), Post Traumatic Stress Disorder (PTSD), panic disorder, obsessive-compulsive disorder, borderline personality disorder, co-occurring brain disorders and addictive disorders, to family members of veterans suffering from these challenges. It supplies up-to-date information about medications, side effects, and strategies for medication adherence. During these sessions participants learn about current research related to the biology of brain disorders and the evidence-based, most effective, treatments to promote recovery from them. Family members gain empathy by understanding the subjective, lived experience of a person with mental illness. Our Family to Family volunteer teachers provide learning in special workshops for problem solving, listening, and communication techniques. They provide proven methods of acquiring strategies for handling crises and relapse. Also, Family to Family focuses on care for the caregiver, and how caregivers can cope with worry, stress, and the emotional overload that attends mental illness in families. We at NAMI are very proud of Family to Family, and we were especially pleased last year that Under Secretary Michael Kussman and VA's Office of Mental Health saw the wisdom of finally bringing NAMI resources like Family to Family into VA mental health programs at the local level.

Mr. Chairman, section 7321 of title 38, United States Code, requires VA to appoint a "Committee on Care of Veterans with Serious Mental Illness," with clearly defined duties: to identify system-wide problems and specific VA facilities at which program enrichment is needed to improve treatment and rehabilitation, and to promote model programs that should be implemented more widely within VA's mental health practice. These are the expectations of Congress for that committee. Since 2006, however, this Committee—an activity that at one time displayed inspired leadership and effectiveness in meeting this Congressional mandate—has seemingly become a functional arm of VA Central Office (VACO) leadership, and is no longer an independent voice for better services for the most vulnerable enrolled patient population: the chronically mentally ill. As an endorsing organization that holds designated seats on this Committee, NAMI is in full agreement with the *Independent Budget* for FY2010 that the current committee structure and function should be replaced by another activity that has more independence and an ability to communicate its findings directly to the Secretary of Veterans Affairs and to Congress without interference. NAMI joins the *Independent Budget* in urging the Committee to take appropriate steps to reform this function.

I joined the fight for better care for our returning servicemembers' post traumatic stress injuries after losing my step-brother, Chris Dana, to a Post Traumatic Stress Disorder (PTSD)-induced suicide approximately fifteen months after he returned from Iraq where he served as a Humvee machine gunner with the 163rd Infantry Regiment of the Montana National Guard.

Chris's death was an ugly, painful, and needless tragedy. However, it did spark a major campaign in Montana for better treatment for our servicemembers and vet-

erans who are struggling with mental illnesses. The Governor put together a task force to analyze the problem and make recommendations. In October 2007, the Montana National Guard implemented all of the task force's recommendations. By the summer of 2008, the National Guard Bureau recognized that Montana had implemented the best system in the country for caring for post traumatic combat stress injuries, depression and other readjustment challenges.

Personally, I ended up giving up my practice as a corporate attorney to serve as Executive Director of NAMI Montana. In that role, I would like to explain to you some of the challenges that we have in treating Montana's veterans that are struggling with mental illness.

All of the challenges are tied to the fact that Montana is the fourth largest state with a relatively small population, less than a million people. The state of Montana contains an area of approximately 147,046 square miles. That area is large enough to fit more than thirty-six of the Big Island of Hawaii. Montana is over three and a half times the size of the state of Virginia. We are also double the size of the State of Washington.

The population of Montana has a significant need for treatment for combat-related mental illnesses. We are also among the leading States in both the percent of wartime casualties per capita and the percent of wartime injuries per capita. I think that it is therefore a reasonable assumption that Montana is also among the highest States in PTSD related to the conflicts in Iraq and Afghanistan per capita.

The logistical challenges of treating veterans with severe mental illnesses scattered across a state the size of Montana are obvious. But they are compounded by Montana's lack of a strong mental illness treatment infrastructure for the VA to rely upon as a safety net. In NAMI's 2006 Grade the States Report, Montana's system for treating seriously mental illness graded out at an "F." Based upon that grade, the VA cannot expect that the State of Montana will be able to provide treatment for veterans with mental illness who fall through the cracks of the VA system.

While the Montana VA has admirably been able to utilize telemedicine to overcome some of the logistical challenges, some treatment challenges cannot be resolved with high technology fixes. For example, our state desperately needs geographically dispersed crisis beds to serve veterans in rural areas that have a mental health emergency. Put simply, if a veteran threatens to commit suicide in Scobey, Montana, we do not have a humane way to handle that threat. The distance from Scobey to our state mental hospital is 534 miles, an eight hour drive. That is a long time to have one of our combat heroes shackled in the back of a police car. It is also a long time for a small community that may have only three or four law enforcement personnel to give up a deputy and a patrol car.

We need to ensure that the VA has access to, or can arrange, geographically-dispersed crisis beds to ensure that no veteran must be made to travel more than two or three hours to get to a safe place of care.

The crisis beds issue is becoming even more critical due to the waiting periods at the Department of Veterans Affairs' inpatient mental health treatment facilities. Last month, I worked with Senator Tester's staff on the case of a Marine combat veteran with PTSD who had a co-occurring substance-use dependency problem. This veteran had been court-ordered into inpatient treatment because in the opinion of the court he needed immediate and critical help. The veteran was placed on a VA waiting list in November 2008 for an opening in March 2009. The court contacted me at the end of January when they were worried that the veteran was going to kill himself. Thankfully, Senator Tester's staff ensured that the veteran got the help that he needed, but this veteran's plight highlights the fact that our failure to treat a veteran's mental illness at a preliminary stage will eventually lead to a higher and more expensive level of care.

In the case of a crisis, it's a level of care that the State of Montana really needs the Federal Government's help on, because we cannot do it alone—especially given the current financial situation.

That brings me to another important point. One of the major lessons from Chris's death is that we can't afford to wait for symptoms of the illness to become so overwhelming that servicemembers either reach out for help or have their lives collapse. In response to our bitter lesson, Montana implemented a face-to-face screening program for all of its returning servicemembers, upon redeployment and then every six months afterwards for two years.

These screenings help open the way to provide effective treatment when the disease is in its initial stages. Just like any other illness, early treatment is more effective from both a medical and cost standpoint. In human terms, it can make the difference between whether a veteran moves on to be a productive member of society, ends up on the street—or worse. In VA financing terms, early intervention and treatment can lead to lower health care costs and reduced disability ratings.

These screenings will allow the Department of Defense to treat military personnel's mental illnesses when they first arise, not drop them off on our rural VA health care system one step away from a full blown psychiatric or substance abuse crisis.

I have been working with Senator Baucus and Senator Tester on developing draft legislation to implement the Montana Model on a national scale for the active duty, reserve and National Guard units and members who are coming home from combat deployments. I would really appreciate your support for that legislation.

To summarize Mr. Chairman, in the year following my step-brother's death, I was overwhelmed by the calls and letters that I received from veterans and family members who needed help. So I joined NAMI and gave up my practice as a corporate attorney to focus on advocating for people affected by severe mental illness. In that role, I have noticed three glaring issues that need to be addressed.

The first issue is that we need to reduce the waiting times to gain access to inpatient mental health treatment facilities. Thankfully, as I mentioned earlier, Senator Tester's staff ensured that a veteran in crisis was admitted earlier than VA had planned. But let me ask you: should we need to rely on a U.S. Senator's intervention to get a combat veteran into a critical VA treatment program that might save his life?

The second problem, especially important in Montana and other rural and frontier States, is that we need access to appropriate beds for our veterans who are in mental health crisis. The bottom line for me is that we need to ensure that the VA has access to, or can arrange, geographically dispersed crisis beds to ensure that no veteran must be made to travel more than two or three hours to get to a safe place of care.

The third concern is that diversionary courts can be excellent tools to get veterans who are struggling with mental health issues the help that they need. In the instance of the Marine I described earlier, the drug court likely either saved his life or kept him out of prison. We have a mental health court in Missoula that is similarly effective at helping sick veterans receive the help they need. I have even read about a "Veterans Court" that was established in Buffalo, New York, designed to help combat veterans who have fallen through the cracks. I would urge this Committee and the VA to support the development of these diversionary courts for veterans, and especially combat veterans, and to make sure that VA reaches out and coordinates with the existing courts system to ensure the most timely and effective care possible, rather than allowing sick and disabled veterans to be convicted and go to jail or prison.

Mr. Chairman, my colleagues at NAMI's national office also asked me to highlight for the Committee a current collaboration between the Department of the Army and the National Institute of Mental Health (NIMH), on the development of effective suicide prevention strategies. According to my NAMI colleagues, the Army Secretary and NIMH Director have made this initiative a top priority for their respective agencies. I certainly agree it is critical that both the Army and the VA more effectively engage with the NIMH to ensure that suicide prevention efforts are grounded in sound scientific evidence, but I would also add from my experience that the Army's efforts should extend to involvement of the National Guard Bureau and all the State National Guard adjutants, to bring these efforts to the ground in rural America, where our Guard members reside and must live after serving their deployments in combat.

Mr. Chairman, the National Alliance on Mental Illness is committed to supporting VA efforts to improve and expand mental health care programs and services for veterans living with serious mental illness. Our members directly see the effects of what the national Veterans Service Organizations have reported through the *Independent Budget* for years: chronic under-funding and late funding of veterans' health care has eroded the VA's ability to quickly and effectively respond to present-day and projected requirements, even with the infusion of new funds it now is receiving. Until very recently forward motion has been stalled for years on VA's "National Mental Health Strategic Plan," to reform its mental health programs—a plan that NAMI helped develop and fully endorses. NAMI wants to see VA back on track for improved access to mental health services for veterans returning from Iraq and Afghanistan, as well as others diagnosed with serious mental illness—all important initiatives within the VA strategic plan. NAMI hopes the Committee will agree that oversight of VA's implementation of the National Mental Health Strategic Plan and its recent announcement of a "Uniform Mental Health Service" benefits package, would be beneficial to ensuring its progress toward full implementation, to provide help to the newest war veterans and all veterans who live with mental illness.

Mr. Chairman, this concludes my formal testimony. My colleagues at NAMI's national office and I hope you will take all of our views into consideration as you con-

duct the important work of this Committee. Thank you again for inviting me to testify. I would be honored to answer any questions that you might have.

Chairman AKAKA. Thank you very much, Mr. Kuntz. We are certainly glad to have you here. I will now defer to Senator Tester for his questions.

Senator TESTER. Yes, thank you, Mr. Chairman. We will just kind of go down the line.

Reverend Flippin, I have a couple questions on the CARE-NET program. First of all, is it Statewide?

Rev. FLIPPIN. Yes, it is. It covers all 55 counties.

Senator TESTER. That is good. Do you know—how is a person referred to your program?

Rev. FLIPPIN. Through ten mini-grantees that we have dispersed throughout the State of West Virginia. Initially we were funded with enough money to go out and subcontract within our rural communities so we would be able to find out exactly what is going on. So we have our feelers throughout the State.

Senator TESTER. OK. And I assume those same feelers that make the referring, they also know who to match people up with?

Rev. FLIPPIN. No, they do not.

Senator TESTER. How do you do that?

Rev. FLIPPIN. That then becomes my job. [Laughter.]

Let me give an example of what may happen. We receive a phone call from a young lady who is 20 years old, has a 2-year-old son; she is 4 months pregnant, and her husband in the Guard is currently in Afghanistan. She is having trouble trying to find a provider, and so she calls CARE-NET. I then call a local area in West Virginia and ask them to find us a provider who will at least talk with her and get her on the right track. That is basically it.

Senator TESTER. Very good. How do you deal with issues that revolve around mental health? Or do you?

Rev. FLIPPIN. Could you repeat that question?

Senator TESTER. Excuse me. I will try to do it without the cough. How do you deal with issues that revolve around mental health? Or do you? Is that in your purview?

Rev. FLIPPIN. Basically, we will do a referral. We will call someone in the mental health area, and then we will ask them for direction.

Senator TESTER. All right. Well, I absolutely appreciate your work. Thank you very much for being here.

Mr. Watson, you talked about your hospital facility in Tennessee, and I am just curious. Do you have mental health capabilities in your hospital? Do you have mental health professionals on staff?

Mr. WATSON. We only have mental health capabilities for senior adults—that basically is 55 and over. The younger adults that require mental health capabilities, we must seek care in larger communities where there are mental health facilities.

Senator TESTER. I got you. So that would be—you talked about the hospitals being 1½ and 2½ hours away. That is where they would be typically?

Mr. WATSON. For veterans, yes, sir.

Senator TESTER. How about for regular folks? How far would they——

Mr. WATSON. For regular folks it would be 1 hour to Knoxville or 45 minutes to Oak Ridge, Tennessee.

Senator TESTER. OK. Just your perspective, and I am going to ask you the same question, Mr. Loftus, because you deal with community health centers. You are dealing with a hospital. Do you think there are negative impacts that could happen on the VA with contracting services to hospitals? And you will get the same question about the community health center. Do you think there is any negative impacts to that? And if there are, what are they? Or if there are none, that is fine.

Mr. WATSON. I do not believe there would be negative impacts. I think it would actually enhance the services that the VA is currently offering by contracting with local providers to take care of those veterans before it becomes an emergency.

Senator TESTER. Good. How about you, Mr. Loftus?

Mr. LOFTUS. Yes, I agree with that. As a matter of fact, there is a pilot test in VISN 6. The principal investigator is Dr. Harold Kudler, who is the head of VISN 6 psychiatry. I serve on a committee with him called "Virginia for Heroes." We are doing a pilot test in Hampton, Virginia, where the VA works with the local Community Services Board, which are mental health services and field welfare offices. We were trying to get the PTSD/TBI assessments done at the lowest level in the community so these undiagnosed veterans can be screened and processed. This is a consortia between the State of Virginia, the Virginia Commission on Veterans, the Medical School of Virginia in Richmond, and VISN 6-Durham, North Carolina.

The answer to your question is no, there is no stigma to it, as far as I am concerned.

Senator TESTER. Actually, I am not talking from a stigma standpoint, just the numbers, I mean for providers. Your hospital has to have a certain number of patients to maintain a level of profitability. The same thing with the clinics. If you are going to stay open, you have to have a certain number of people.

I guess the question I had is if we—and I agree there is need for contracting services, but I do not want to take away from the VA's effectiveness by pulling down their numbers. But you do not see that as a problem?

Mr. LOFTUS. No, no. The biggest problem is reimbursement. That is your biggest problem. Community health clinics only have four payers: the medically indigent, the Medicaid, the Medicare, on a sliding-fee schedule, and commercial pay.

Senator TESTER. Right.

Mr. LOFTUS. So, actually, the fusion of VA patients who are insured would actually be a boon to them.

Senator TESTER. In Virginia, are there any cases where CBOCs are combined with community health care centers?

Mr. LOFTUS. No. There is a CBOC in Danville, which is about an hour from where we are. But because of some idiosyncracies with the VA, there are medical records issues. If you signed up in Richmond and you go to Danville, you have got to take all your records from Richmond and take it to the Salem Hospital. So, there are territorial problems with the VA.

Senator TESTER. OK. I have got more questions, Mr. Chairman, but my time has run out. I will do another round if we can.

Chairman AKAKA. Thank you very much.

Senator Burris?

Senator BURRIS. Thank you, Mr. Chairman. I would just like to commend the panel for your work in this area. It is going to take dedicated persons like you coming before us to make the case and let it be known what is going on out there.

I would like to ask Reverend Flippin, Do you find your resources are strained by the need of veterans in West Virginia for professionals helping vets? Do they provide these services pro bono or at a discount? And what happens if the vet cannot afford the treatment?

Rev. FLIPPIN. That is a complicated question for the State of West Virginia, and I would like to do that for the record.

Senator BURRIS. OK. Thank you, sir.

[The information requested was not received by press time.]

Senator BURRIS. Mr. Watson, the issue in your area with access and continuity of care for veterans, why has this not been addressed previously? Or is it something that is just coming up? And what is the biggest weak link that has led to this failure to serve?

Mr. WATSON. I think it has always been a problem for rural communities, for veterans to just get to the local VA facilities—2½ hours to one facility, 3½ to another. So I do not think it is a new issue. It has been ongoing for years.

Typically what has happened is the veterans just seek care among the routine medical systems and avoid using VA systems, if at all possible, just because of the distances. There do become times when veterans have to access the system, and I think that is when they begin moving to drive those distances. But I do not think it is a new problem that has just occurred.

Senator BURRIS. Now, would some of these be some of the Vietnam veterans who for so long did not come forward and now maybe some of them are coming forward, which is perhaps impacting the system more than it would normally? Not counting Desert Storm or the current Iraq/Afghanistan situation.

Mr. WATSON. I think many of them have had private insurance through their employers, and so they have sought care among the local community providers. As they become unemployed or they retire and no longer have full coverage from their employers, then they will seek care among the VA system.

Senator BURRIS. Do you see an increase in that, a pick-up from actually the Vietnam vets? Because they had all that confusion about those individuals who served, and they were really treated not so grandly when they returned home. And some of them were ashamed to even let it be known that they were Vietnam vets, which is just unconscionable.

Mr. WATSON. I cannot say that we have seen an increase in numbers per se. It is just the traditional progress. If they no longer have commercial insurance or need supplements to Medicare and those type things, then they begin seeking care.

Senator BURRIS. And one last question. Mr. Kuntz, how could the VA set up geographically diverse crisis beds for these mentally ill

patients? And where would they be located in your State? Or how would they be staffed? Do you have any thoughts on that?

Mr. KUNTZ. Senator Burris, I think realistically it will have to be contracted out. In our State, if I was in charge, I would probably put one in Glasgow, Montana, in our northeast; one toward Glendive or I might actually just put money into Billings to make sure that their clinic stays open, because they have got a clinic but it is closing; potentially Kalispell in our northwestern section; and I would probably be happy with the State hospital in the southwest, potentially Lewistown in the central—but I think it is going to have to be a partnership with our hospitals, and it is going to be private staffing.

We are working with the counties in the State to try to get them in, but I think that we are going to need some additional help, Senator.

Senator BURRIS. Mr. Chairman, thank you very much.

Chairman AKAKA. Thank you very much, Senator Burris.

You have just talked about working with VA. That is what we hope can be improved. Let me ask each of you that question.

From your vantage point, how could VA best work with you and your organization to help that? Reverend Flippin.

Rev. FLIPPIN. First of all, I would say that the Veterans Administration and the Veterans Affairs Office, I think they have developed such a tight, bureaucratic organization that they do not welcome or they do not court outside assistance. I firmly believe that if we are going to be a bridge to our veterans, the community at large must be involved. The community at large cannot be closed out because we are not military.

As an example, the community does not feel they are a part of the military force because they are not called upon to be directly involved in most of the activities that occur. And I find that to be the situation where I am daily dealing with the National Guard and the local community—the National Guard, they are doing a great job as far as referring their personnel. However, it is like a closed society, and the community wants to be involved in supporting our military veterans. The civilian community needs to be educated as well as the VA needs to realize that the good job they are doing is not getting to the community at large.

And so, again, to summarize, I do not really believe we are going to help the invisible wounds, the mental illness and so forth, unless the civilian community is actively involved. And I am not talking about reaching out to churches; I am talking about reaching out to local community agencies who are nongovernmental or non-military aligned. And I thank you very much.

Chairman AKAKA. Thank you, Reverend.

Mr. Watson?

Mr. WATSON. I believe that the best way for VAs to work with local community providers is just through partnerships. Use the physicians that we have in the communities to take care of the patients early in their disease processes. When we do have to admit them to a local hospital, make it easier for us to provide that care for them locally, if possible. If not, make it easier for us to transfer them to an appropriate level of facility as close to home as possible.

And, finally, reimburse us when we do take care of these patients in a timely manner. As I said, ¼ of our population is below the poverty level. We are already caring for a lot of folks that cannot afford to pay. And when we take care of a veteran, we need to be reimbursed timely and reimbursed for the cost of that care.

Chairman AKAKA. Thank you.

Mr. Loftus?

Mr. LOFTUS. Mr. Chairman, yes, I would like to propose that the VA actively look at doing a pilot test in the South Side of Virginia. We have got seven community health centers there. They are all brand-new, very modern. And there is a CBOC scheduled to be built in 2012 in Emporia. I do not know what the status of that is, but I certainly think we can implement many, if not all, of the recommendations that this Committee heard this morning as a pilot test. Thank you.

Chairman AKAKA. Thank you.

Mr. Kuntz?

Mr. KUNTZ. Mr. Chairman, one of the critical things is educating family members. People with mental illness who have educated family members do better, and they are cheaper to treat. And the VA is partnering with NAMI to offer the family course. It is a free 12-week course, and we just started up one in Helena last week; and we are pretty excited about it. I would have given anything to have taken that course when our family needed it.

But one of the things that we need to do is work with the VA on offering that course via teleconference, because it is going to be hard to get family-to-family in Molokai or in Heart Butte. But we can do it via teleconference when they get the teleconference equipment in Molokai.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you so much. Thank you for your responses.

I am going to ask Senator Tester for his questions and also to preside as Chair of the Committee.

Senator TESTER [presiding]. Thank you, Mr. Chairman. Thank you very much. I have just a couple more questions.

Thank you all for being here. I mean that as sincerely as possible. I appreciate your opinions and perspectives. I have got a few questions for Matt real quick.

You know full well about Montana's National Guard program that is requiring a face-to-face, in-person mental health evaluation for soldiers returning from combat. It is something that you addressed in your comments. How do you see that program working? Is it successful? Is it worthwhile? Is it money well spent? Is it time well spent?

Mr. KUNTZ. Senator Tester, I think it is a brilliant program that helps get the National Guard members who need help in before their life spirals out of control and they reach for help. We would throw them the line before they ask for it. And with mental illness, it is utterly critical to get early treatment, and it is far more expensive if we wait. And I think that the best proof for how well this is working is from the Montana National Guard's own actions. They have already been recognized as the best National Guard in the country at dealing with this. But this was originally funded,

this face-to-face screening using LCPCs—our counseling session once every 6 months for 2 years upon redeployment—was originally funded by a grant from TriWest, and that grant ran out. And the National Guard immediately picked it up. There was no doubt that this was helping their soldiers.

Senator TESTER. If you think back to your brother's situation, was there an evaluation with him when he came out? I am talking about a mental health evaluation.

Mr. KUNTZ. There was a brochure that he was asked to fill out, Senator.

Senator TESTER. Was his hidden injury—could it have been caught if there was an evaluation, in your opinion?

Mr. KUNTZ. I believe so, Senator. I think that it may not have been caught immediately after redeployment, because I talked to him then, and he knew that he had some things that he was struggling with, but he thought it was just part of what he participated in. But the genius of the Montana screening model is it happens every 6 months. So, I do not think that they would have caught it upon redeployment. But, really, in my heart I believe that if they would have sat down with Chris 6 months later—when he could no longer go to drill, when he was having the flashbacks, when he was having trouble dealing with his own family—that is when that counselor could have got him to come out of his shell. But I will tell you, we tried later, a year later, and it was too late.

So, we need staged things, because these things get worse. It is just like cancer or anything else.

Senator TESTER. OK. Well, I certainly appreciate the perspective on a very difficult situation, and I once again want to echo what the Chairman said about the appreciation for you guys being here. We appreciate your time and appreciate your wisdom.

We are adjourned.

[Whereupon, at 12:04 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. BERNARD SANDERS, U.S. SENATOR FROM VERMONT

Thank you Mr. Chairman for calling this hearing today which focuses on such an important issue for every Member of this Committee because we all have rural areas in our states and suffer similar but also unique challenges in providing care to veterans in those areas. I want to welcome our witnesses who are with us today.

Mr. Chairman, 12 out of Vermont's 14 counties are either defined as entirely or mostly rural by VA. We have approximately 55,000 veterans in a state of roughly 621,000. In other words, veterans make up nearly 9% of the population. We have beautiful towns and communities in Vermont but many of them are isolated and have trouble attracting quality health care providers and are far away from VA facilities.

The FY2010 *Independent Budget*, which was just recently released, contains some interesting statistics on rural America and health which they compiled from a number of sources. Let me just list a few:

• "Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and concerns for stress, depression, suicide, and anxiety disorders as major rural health concerns.

• Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas.

• The smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high-quality health services.

• Nearly 22 percent of our elderly live in rural areas; rural elderly represent a larger proportion of the rural population than the urban population. As the elderly population grows, so do the demands on the acute care and long-term-care systems. In rural areas some 7.3 million people need long-term-care services, accounting for one in five of those who need long-term care."

More specific to veterans, the *IB* states:

• "There are disparities and differences in health status between rural and urban veterans. According to the VA's Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans 'have worse physical and mental health related to quality of life scores. Rural/Urban differences within some VISNs [Veterans Integrated Service Networks] and U.S. Census regions are substantial.'"

And let's take a moment to discuss where the members of our Armed Forces come from and return to when they are finished with their service. *The Independent Budget* notes that:

• "More than 44 percent of military recruits, and those serving in Iraq and Afghanistan, come from rural areas.

• Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive VA compensation.

• Among all VA health-care users, 40.1 percent (nearly 2million) reside in rural areas, including 79,500 from 'highly rural' areas as defined by VA."

In Vermont, like elsewhere in the country, many of our newer veterans are members of the National Guard and Reserve. As we all know, since September 11th, the Guard and Reserve have been called up to active duty in unprecedented numbers. Since that time more than 450,000 of these part-time soldiers have deployed to Iraq or Afghanistan; more than 800 of them have died.

We need to make sure that the VA properly cares for these citizen-soldiers that have given so much. Frequently they are not as familiar with the benefits they are

entitled to and often do not have easy access to DOD military health facilities. This is the case in Vermont where we have no active-duty military installations.

Given these challenges, we must redouble our efforts to provide both excellent VA care and access to that care in rural areas. Here are some of my priorities and interests in VA's work in this area:

1. Continue the Expansion of CBOCs and Vet Centers: I believe everyone on this Committee hears about the benefits of CBOCs and Vet Centers back in their states. We need more of them to provide health care, counseling, and other services closer to where veterans live, especially in rural areas.

2. New Transportation Models: We need to explore new ways to develop programs partnering local, county, and state transportation agencies with those programs already operated by the Disabled American Veterans and the VA so that we can increase the help provided to bring veterans to the VA care that they need. I know that currently there are certain limitations on the type of VA patients that the DAV or VA employees can transport to VA for care and we need to examine changes to those rules. We need to use existing programs as much as possible and make sure we are leveraging resources that are already in place.

3. Caring for Families: When we talk about care for veterans in rural areas we also need to make sure that we are talking about care for rural families of veterans. It is not just the veterans that may be isolated from care. We need to make sure that we are using the new authority which Chairman Akaka pushed for last Congress to allow the VA to provide more counseling services to the family members of veterans. What can we do to get more rural families of veterans to the VA?

4. Increase the Use of Telehealth Services for Mental Health Counseling: In the White River Junction VA Medical Center in Vermont we are currently working on a pilot program proposal where the medical center would partner with a federally Qualified Health Center (FQHC) and a Community Mental Health Center (CMHC) to serve as locations to facilitate tele-mental health services. This would allow a veteran to come into a FQHC or CMHC and link up over a secure network with a VA mental health clinician down at the medical center. We are still in the development stages of this proposal but I hope it can become a model to be replicated in other parts of Vermont.

5. More Peer-to-Peer Outreach: In recent years the VA has taken steps to improve its outreach to veterans using advertisements, letters, and phone calls. These are good steps but more needs to be done. Especially in rural areas, we need to do more peer-to-peer outreach where we use VA-trained veterans, preferably combat veterans, to help reach out to returning servicemembers, older veterans, and their families to make sure they know about and can access the services available to them at the VA, DOD, state and local agencies, and the profit and non-profit sectors. This could be for health care services but it could also be child care needs, employment, legal advice, etc. We have a program in Vermont that does this known as the Vermont Veterans and Family Outreach Program and it is quite effective. To date, over the last two years, the program has contacted 2,024 servicemembers and veterans and worked with them to fill out VA-developed mental health and TBI questionnaires and where appropriate, connect them to relevant services.

6. Better Pay for VA Employees: In order to provide good quality care for our veterans we have to make sure that we have enough well qualified staff and that we do everything we can to retain those we have and attract others. In Vermont, the challenge we are experiencing is that the locality pay that determines how most of our workers are paid is not updated frequently enough and we are losing VA employees to other VA facilities in nearby states where pay is better. We need to make sure VA employees are paid competitive salaries so that they can afford to stay in rural areas.

7. Do More to Expand Collaboration Between the Health Service Corps and VA: In preparation for this hearing, Committee staff research found that "the VA does not currently use certain Federal resources, such as the National Health Service Corps, to support its efforts." I am a strong supporter of the National Health Service Corps and have worked to increase funding for them by $75 million in the American Recovery and Reinvestment Act that President Obama recently signed into law. I strongly urge the VA to develop a partnership with the excellent medical professionals that are part of this program. I am aware that the VA has other outstanding programs for recruitment and retention of nurses, physicians, and other health care professionals in rural areas. I believe partnering with the Health Service Corps would greatly compliment your efforts. We obviously don't want to drain the Health Service Corps staff from other areas in need but surely more can be done to work together.

These are just some of the steps I think we need to take in order to improve the care for our rural veterans and their families. I believe the VA has made significant

progress in this area but we have a long way to go. I look forward to learning about VA's efforts and hearing from the members of our second panel who can tell us how they experience rural VA care in the real world.

Thank you Mr. Chairman.

PREPARED STATEMENT OF HARDY SPOEHR, EXECUTIVE DIRECTOR, PAPA OLA LOKAHI

Aloha Senator Akaka and Members of the Committee, Hawai'i Veterans, particularly those in rural areas, have multitudes of health care needs which presently are not being met by the Department of Veterans Affairs. It is commonplace at community meetings in Hawai'i's rural areas to hear veterans identify their major issues and concerns: (1) lack of local access to primary care and specialty services; (2) lack of culturally sensitive health care providers; (3) inordinate amounts of time in communication, i.e. slow processing or no processing; and (4) lack of folks who can communicate effectively with them and inform them of their rights and services available to them. Often times these issues and concerns could be resolved very simply by having local health service providers already in these rural areas provide these veterans with their health care needs. Unfortunately, to date, the Department of Veterans Affairs has not seen fit to contract with community health centers or our Native Hawaiian Health Care Systems and/or other providers which could address our veteran's health care needs right in their own respective communities. We would ask the Department begin to look at how best it could use existing service providers in rural areas to provide health care services to veterans. Unlike many VA clinics, most often the service providers themselves come from the same communities as do the veterans so there is instant rapport.

Papa Ola Lokahi (POL), the Native Hawaiian Health Board, also would like to put forth the concept of utilizing the network of Native Hawaiian Health Care Systems (NHHCS), which operate throughout the State of Hawai'i—on every island—providing services to Native Hawaiians and others who avail themselves for health services. This network could be a valuable asset to the VA and its network of clinics.

With the NHHCS, POL has recently undertaken a major veterans' health initiative under the director of veteran Clay Park to better identify what the local issues are around health care for veterans and how better to address their identified needs. We would certainly look forward to assisting the Department of Veterans Affairs in any way that we could to improve the abilities of veterans to access and receive quality health care in rural areas in Hawai'i.

Thank you for this opportunity to provide testimony on this critical matter for our country which has asked so much of our veterans.

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